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SOCIAL WORK FACES THE FUTURE

SEATTLE, its streets alive with sailor boys—for the fleet was in with 20,000 sailors ashore, so they said—offered cool winds and cloudy skies to the 3500 social workers who gathered for their national conference during the last week of June.* Physical arrangements, always an important item in the impression made on delegates by the hostess city, were reasonably comfortable, and distances between meeting places not too purse-breaking. It was almost a major victory for the easterners to reach Seattle at all; but most of those scheduled to speak arrived safely in spite of three serious train wrecks, a shipwreck, and a fire, on the routes.

Four subjects developing and maturing from previous conferences came into their own in Seattle and drew the crowds. The Section on Social Action presented a series of meetings dealing with the organization of labor and the relation of political parties to social action. These discussions swept all the way from the values of union organization among social workers to the problem of a national health program.

Running parallel in interest for pub-

lic health nurses were two sessions offered by the Committee on Medical Care. The relationship of social work and medical care and the question of meeting the medical needs of the indigent through some sort of national plan were presented by physicians and social workers and discussed by both from widely divergent points of view. Twice, the closing of the meeting left the questions of social workers unanswered.

Following the example set by the United States Children's Bureau in calling a conference of medical social workers and public health nurses in March, the American Association of Medical Social Workers invited a discussion of relationships between these workers. Papers were presented by Ruth E. Lewis, of St. Louis, Missouri, President of the American Association of Medical Social Workers, and Dorothy Deming, General Director of the National Organization for Public Health Nursing. Miss Deming also was one of the guests of honor at the twentieth anniversary dinner of the A.A.M.S.W., at which Ida M. Cannon, Chief of the Social Service Department of the Massachusetts General Hospital in Boston, gave the address.

The fourth topic of special interest to public health nurses was the visiting

*The National Conference of Social Work for 1938 was held in Seattle, Washington, June 26-July 2.

housekeeper service. This meeting was held under the auspices of the Section on Social Case Work and dealt mainly with the use of visiting housekeepers by case-work and child-caring agencies. The basic problems and policies, however, belong to any community service. Public health nurses pointed out the importance of adequate instruction for these housekeepers if they are working in homes where there is illness, and the desirability of their supervision by graduate nurses.

EVERYWHERE throughout the conference meetings one gained the impression of a fast-changing scene: the expansion of public agency work; the growing maturity and strength of the labor movement and its political influ-

ence on the social issues which both public and private agencies have at stake; and finally the problematical future of organizing all social and health work under professional unions. Discussion on all these points—sporadic and discouraged six years ago—was free and animated, but entirely inconclusive insofar as this delegate could discover.

The courageous facing of the future in spite of uncertainty as to method somewhat reassured the older delegates and acted as a powerful stimulant among the younger groups. As one young delegate—sunburned and dressed in slacks, dark glasses, and beach hat—was heard to exclaim as she left a session, "Never mind. Time will teach the old guard to trust us!"

D.D.

SWIMMING AND THE EARS

HEALTHY EARS are not injured by water because their outer canals are lined with skin, and water in moderation will not injure skin. It will, however, cause any fibrous or waxy material in the external ear canals to swell up and produce pressure and temporary deafness. It may infect the middle ear if there is a hole in the eardrum. A tightly fitting cotton ear-plug saturated with vaseline will prevent water from entering the ear, but such a plug will also largely prevent sound from entering the ear.

The reason that swimming may cause harm even to the healthy ear is that infectious material which gets into the back of the nose near the opening of the Eustachian tube may be sucked in whenever the middle ear becomes deflated, following forcible snuffling or swallowing with the nose obstructed. This creates a partial vacuum in the middle ear, and it then acts like a rubber ball with a hole in it, squeezed under water; when the vacuum is released, anything near the tubal open-

ing will be sucked up towards the ear.

This is the way in which infectious material in a person's own nose, or from the noses of others in the sea, lake, or swimming pool, may be drawn into the ear. All noses contain bacteria, and there are many diseased noses which harbor them in large numbers. Anyone with an infection of the ears or nose should be prohibited from bathing near other people.

Holding the nose only prevents water from going into the nostrils but does not prevent the partial vacuum in the back of the nose and often in the middle ear, following swallowing or efforts to breathe through the nose.

It is impossible to keep the nose above water when using the crawl stroke or when diving. The old breast stroke is the safest because the head is forward or erect and the tubes to the ears are more nearly vertical, so that in this position nothing can be forced into them against the retained column of air.

—American Society for the Hard of Hearing,
Washington, D. C.

The Treatment of Pulmonary Tuberculosis

BY DAVID ULMAR, M.D.

New York, N. Y.

Important points in the treatment and prevention of recurrence of tuberculosis are discussed by a specialist who thinks primarily in terms of the individual patient's needs

THE EXTENT and severity of a tuberculous reaction is proportional to the massiveness of the stimulating dosage of tuberculous material. This gives rise to the various forms of clinical tuberculosis that are observed in the adult, from the slow, truly chronic tuberculosis to the acute, rapidly fulminating affair which is popularly known as "galloping consumption."*

As might be expected, the treatment of pulmonary tuberculosis will be markedly affected by the type and extent of the pulmonary response to the tubercle bacilli. In a general way, the treatment of any disease may be divided into two main categories: (1) the care and management of the pathology as it now exists, (2) the prevention of future relapse or recurrence.

With regard to the first problem, namely, the care and management of the disease as it now exists, one is faced with a peculiar situation. Here is a disease whose bacterial agent is known, and whose pathological responses have been well studied. And yet no vaccine, serum, or chemical has to date been found efficient for the resistance of its onslaught. This being the case, the patient is forced to rely on his own ability, whatever that may be, to combat the illness. Experience has demonstrated that the best way of aiding the body's natural defense is by resting. Exactly what constitutes the mechanism of this aid by resting we

do not know. It is merely an empirical observation that true resting aids recovery. A corollary of this remark is that the routine of rest must be continued till no further benefits can be derived thereby, which means that resting must be continued as long as there is inflammation to subside.

It must be kept in mind that the inflammation due to tuberculous allergy is somewhat slower in its clearing up than are some other inflammatory reactions. Therefore, the period of rest has to be correspondingly longer. A complicating factor is added in those cases which have had a reaction of such severity as to produce lung destruction. Here rest must be continued as long as there is a possibility of contracture of scar to close off the disease area, or development of further scar to strengthen that already laid down. The length of time that will be required to fulfill these conditions in any one case obviously cannot be stated arbitrarily. It will be gauged by the clinician's judgment—based on close observation of the patient—and his concept of the underlying pathology.

In a similar fashion will the degree of rest be determined. Generally speaking, if one is to institute a regimen of rest, total bed rest is the ideal. Unfortunately we can not all achieve an ideal, and it is possible for the patient to follow a rigid bed routine only as long as his will power and reasoning ability make him capable of enduring the ennui of the couch and resisting the temptations of

*See "Pathogenesis of Tuberculosis," by Aaron E. Margulis, M.D., and Max Pinner, M.D., PUBLIC HEALTH NURSING, July 1938.

a more active life. The true physician is the one who by his persuasive logic can convince the patient of the necessity for rest and who by his knowledge of human behavior and human frailties knows when and how to compromise.

Inasmuch as this first phase of treatment is largely a passive one that requires prolonged and intensive bed rest, the duties of the nurse become manifold. The responsibility for the care of the patient rests to a large extent on her shoulders alone. One of her primary duties is to make sure that the proper routine of physical inactivity is maintained.

We are all acquainted with the painful experience of the cut on the knuckle of a finger, which cracks open each time the finger is flexed and which refuses to heal until the finger is immobilized. The employment of this simple analogy usually is sufficient to gain the coöperative interest of the patient, who can readily see the similarity between the flexion of a finger and the bellows-like movement of the lung upon respiration. Obviously, the less the activity, the less is the need for respiratory movement and the quicker will healing occur. Once the patient has been convinced of the necessity of this course, he gives voluntary coöperation instead of subconscious resistance. Frequently it is also necessary to use the same logic in talking to other members of the family, in order to gain their help. Without this understanding and sympathy on their part, rest therapy may sometimes be considered as mere lazy malingering.

WHAT IS REST TREATMENT?

Rest treatment in the parlance of the phthisiologist means complete relaxation in bed with the avoidance of any stress or strain on the part of the patient. In its complete accomplishment, it means that the sick person is a bed patient twenty-four hours of the day. No bathroom privileges are permitted. All meals

are served in bed. The patient may be propped in a sitting position or may be flat in bed, depending upon the physician's directions. There should not, however, be a constant, restless changing of position, since this increases activity. Certain activities are definitely and emphatically contraindicated. Thus, strenuous arm movements, such as pushing a bedside stand—which increases intrabronchial pressure and may cause a movement of sputum into a new and hitherto uninvolved area of the lung—is to be severely frowned upon. In fact, straining for any reason should be prohibited. It is also customary to insist upon a two-hour rest period in the afternoon, which is usually taken just after lunch. Shades are drawn, all activities are suspended, and the patient is encouraged to sleep.

NURSING CARE

It is but natural that such intensive bed rest throws an added responsibility on the nurse and taxes her technical skill. A patient who is in bed so steadily must be made to like it by the application of the most careful nursing procedures. It goes without saying that wrinkles in the sheet and crumbs in the bed do not add to a person's comfort and rest. Scrupulous care of the patient must be taken to avoid bedsores, which if they occur in a malnourished individual may be very difficult to clear up. If the patient must remain at home in the interim before he can be admitted to a sanatorium, the public health nurse should demonstrate and teach these essential points of nursing care to the person responsible for giving care in the home.

"FRESH AIR"

The question of ventilation and air is also of considerable moment to the patient. Probably as a violent protest against the dungeon-like rooms of previous hospital construction, the tendency for many years was to place the tuber-

culous patient in a shack which was of no greater protection than an open lean-to. The present trend is toward a more sane middle course. The ordinary ventilation of a room, such as any normal individual requires, is all that is necessary. The temperature of the room should be maintained as nearly as possible at that point which is most comfortable for the patient.

PLANNING THE PATIENT'S DIET

The question of diet for the patient has been a very controversial subject. In a general way I believe it is safe to state that from a qualitative standpoint, the ordinary well balanced diet is the one that should be given the patient. Where there has been considerable loss of weight prior to treatment, the caloric intake should be increased in order to bring the patient up to a normal weight. Excessive gains in weight are not always significant; they may occur while the sputum is still positive and therefore while the disease is capable of continued spread.

When there is a complicating enteritis, the diet must of course be adjusted to the specific conditions encountered. Because of the excessive irritability of the intestinal tract, a nonirritating, low-residue diet should be used. Bland, easily digested foods such as creamed soups, puddings, and similar articles are preferable to the coarse, bulky vegetables or highly seasoned, spicy foods. Likewise, a person with a tuberculous larynx, who has pain on swallowing, must have his diet adjusted. Generally, liquids or semisolid foods are the ones best tolerated by these patients. Inasmuch as the patient is loath to do much swallowing, it is essential to have the amount which is taken as highly nutritious as possible. Thus, soups fortified with lactose are more nutritious than plain soup.

It is important to avoid fads in diet which place undue emphasis on certain

foods or food elements. The patient and family should be taught to withstand the blandishments of advertisements which artfully present misleading ideas under the guise of their being scientific information.

PROTECTION OF OTHERS

The question of care of the patient's dishes is also important. All dishes and eating utensils should be kept separate from the remainder of the household supply. This makes a burdensome but necessary task for the housekeeper. It is my feeling that careful washing with hot soapy water is all that is necessary. Boiling, of course, will insure sterility.

Sputum disposal is another problem. There are on the market a variety of sputum cups. The simplest and cheapest way of sputum disposal, however, is for the patient to expectorate into tissue paper rather than using a cup—which is difficult to manipulate while lying down. The tissue paper can be placed in an ordinary paper bag pinned to the side of the bed. When the bag is filled, the whole thing can be burned without rehandling.

OCCUPATIONAL THERAPY

With so much of the patient's time spent in bed, eventually the problem of occupational therapy arises. It has been customary to spend time at leather punching, jewelry making, weaving, and similar pursuits. This to me has always seemed a rather useless waste. It would be far better to direct the patient's activities into more profitable channels of rehabilitation to fit him for return to a normal life. A careful study of the individual problem in each case, taking into consideration the previous education, experience, aptitude, and other factors, will enable one to set up a long-range program that is really worth while and which at the same time acts as a diversion for the patient. After all, our whole aim in treatment is to get the pa-

tient back to a normal, productive life. Rehabilitation forms an important part in this scheme.

PREVENTION OF RELAPSE

With regard to the second phase in treatment, the prevention of future spread or relapse, volumes could be written; briefly, it may be said to consist simply of the effort to eradicate the tubercle bacillus. After the acute allergic battle in the lung has subsided, an ulcer or cavity may remain at the place where the previous struggle took place. The lung which was destroyed became caseated, and was liquefied and expectorated, so that a hole now remains. Attempts at healing have been simultaneously going on so that the hole, or cavity, becomes lined with scar tissue. The unfortunate part about this scar, however, is that it is a tuberculous scar and is constantly shedding bacilli into the cavity. The germs have ample opportunity to spread through the bronchial tubes to other parts and initiate fresh areas of disease. A person with a cavity and a positive sputum therefore does not need to come in contact with anyone else to contract the disease. He becomes his own contact, and a most intimate one. Experience shows that unless this condition can be corrected, disaster is bound to ensue.

The cavity which is the source of the bacilli is the end stage of a previous acute condition in most instances. As far as the acute phase is concerned, it is over, having been treated by rest therapy. We are now faced with a bad mechanical end result which at the present time can only be tackled by mechanical means. This form of treatment is grouped under the general title of collapse therapy.

COLLAPSE THERAPY

The most popular mainstay of collapse therapy is pneumothorax treatment. In this procedure, air is intro-

duced into the pleural space between the chest wall and the lung. The suction effect which normally keeps the lung snugly against the chest is thereby released, allowing the lung to snap back toward its fixed point at the hilus, a collapsing effect the degree of which is determined by the amount of air that is introduced. As the lung is collapsed and diminishes in size, it is the hope of the operator that the cavity will disappear and the sputum become negative. If this is accomplished, the danger of future spread of disease from this focus is removed. Once the cavity has been closed and the sputum converted from positive to negative, the collapse must be maintained for a length of time which in the operator's judgment will make the cavity closure permanent even when re-expansion of the lung is permitted, for it must be remembered that eventually the treatment is going to be stopped and the lung re-expanded. If all goes well, cavity closure is permanent and the sputum remains negative.

Pneumothorax is not a form of treatment to be undertaken lightly. It cannot be used to prevent the evolution of pathology that has once been started. The main indication for pneumothorax is the control of a positive sputum resulting from a pulmonary cavity. Once initiated, it must be faithfully continued, usually over a period of at least two or three years. This does not mean, however, that the patient is incapacitated during the entire time. After the period of resting has been terminated in accordance with the principles previously described, the pneumothorax treatments can be given to the ambulant patient who may by this time have returned to his normal life. Treatments must be given with sufficient frequency and volume to replace the air that is absorbed, thus maintaining collapse.

Pneumothorax is not without hazards incident to the treatment itself. For example, the needle point may enter a

vein so that air instead of flowing into the pleural space seeps into the circulation, and an air embolus occurs which may be fatal. Due to mechanical conditions peculiar to pneumothorax, tuberculous empyema and even spontaneous pneumothorax with resultant mixed infection empyema may occur—certainly conditions not to be relished by anyone. Another complication of pneumothorax is the presence of adhesions between the surface of the lung and the chest wall. This may vary in extent from the extreme of complete adherence so that no pneumothorax is possible to a single stringlike adhesion which may be of no significance whatsoever. The importance of any adhesion depends on whether or not it interferes with the conversion of the sputum from positive to negative. If the adhesion does interfere, then it must be dealt with according to surgical principles, a discussion of which is not within the scope of this article.

PREVENTIVE MEASURES

It must be remembered that pneumothorax—or any of the other forms of collapse therapy—is only a mechanical means of correcting a bad mechanical end result. It is obviously as wasteful as trying to chase hogs out of a cornfield. The logical thing to do is to put up a hog-tight fence before they can get in, which in tuberculosis means the segregation of the open case and the detection of the very earliest lesions before any real damage has been done. In the medical profession and associated professions this problem becomes serious. The repeated exposure to tubercle bacilli during the course of their work has resulted in an increased incidence of tuberculosis among these groups.

If the early phases of infection are

overlooked, disastrous end results requiring drastic therapy may be necessary. Fortunately, the early detection is simple if routine x-raying of the chest is done every six months. In this way early lesions are discovered even before symptoms are noticeable. Bad mechanical end results are avoided so that all of the mechanical therapy mentioned above is obviated. Simple rest as previously outlined may be all that is necessary, to the ultimate gain of the patient and of the community.

Our job and responsibility to the patient do not end with his return to the normal life. We must see that he stays there. During the critical period following discharge from the sanatorium, when so many readjustments must be made, the supervision should be especially close. Generally, however, these periods between reexamination may be lengthened so that eventually periodic check-ups once or twice a year may be all that are necessary. The success of this plan depends to a great extent on the coöperation of the patient and the family. The groundwork for such coöperation is best laid when treatment is first begun.

The treatment of this disease cannot really be divided into phases. It is one integrated process which, with modifications to meet changing conditions, gradually brings about the return of the patient to normal. All our efforts should be directed toward that goal. The nurse, by her close association with the patient and family, is the key person in this program and is an important factor in bringing about its successful conclusion.

This is the fourth in a series of articles on various aspects of tuberculosis control. An article on "Surgical Treatment of Pulmonary Tuberculosis," by Dr. Iago Galdston, will appear in the October issue.

Intangibles of Good Supervision

BY FLORENCE HOLLIS

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The success of the supervisor depends upon the same factors in her relationship with the worker as does the success of the nurse with her patient—upon understanding, "acceptance," and a realization of the limitations of her role

THE SUCCESS of a nurse depends not only on her technical skills—the importance of which, of course, must not be underestimated—but also upon the kind of relationship, of feeling, that exists between her and her patients. The nurse is not an automaton who bathes, dresses, takes temperature and pulse, and walks silently as a ghost from the room. On the contrary, she is a human being who talks or is silent, smiles or frowns, encourages or discourages, approves or disapproves, likes or dislikes her patients, the things they say and the things they do. This in turn is felt by the patients and affects their response to her ministration as well as their interest in following her suggestions in caring for themselves and taking precautions against further illness.

If this is true it means that the nurse and the social case worker have a certain area in common—namely, that of establishing a relationship with client or patient that will enable him to make the best use of the skills that we each in our respective fields have to offer him. It is because of this that nurses may be interested in some of the principles of supervision by which we try to teach case workers to develop a helpful kind of relationship with their clients.

We consider that three things are of primary importance in this relationship—understanding, acceptance, and a clear conception of the limitations of our role in a situation.

Suppose, for instance, that a case worker is called upon to help a young woman who complains of pains in her back and legs which make it very difficult for her to walk. The doctors say there is no physical basis for these symptoms. They are "imaginary." The worker further learns that this client was devoted for years to her mother who recently died. She is now living with an aunt who completely dominates her but who feels very sorry for her and treats her in a kindly and motherly fashion when she is ill.

LEARNING TO UNDERSTAND

What help does the inexperienced worker need in learning to understand such a person? First, she needs knowledge. She will probably not know the difference between an imaginary illness and a feigned illness. She will probably think that because there is no physical cause for the pains they do not exist, that the client is not suffering, and that she should attempt to persuade the client to become well by trying to convince her that she isn't sick. She cannot sympathize, she cannot understand what this person is going through unless she has some knowledge of such functional illnesses and awareness that the pain is real to the client. It is part of the teaching role of the supervisor to supply this kind of information if there is no other source from which the worker can learn it. In any case, she must find ways of making such new facts real and

logical to her. To do this, she may need to draw on other case illustrations, on other life experiences with which she is familiar, or even on experiences from the worker's own life. The more this can be a participatory discussion with worker and supervisor both contributing, the better.

In addition to lack of knowledge, certain feelings and prejudices of the worker may stand in the way of understanding the client's feeling. She may be a Spartan who looks upon illness as a regrettable weakness. She may melt in sympathy, feeling that the doctors are wrong and there must be a physical cause. She may resent the domineering aunt or have a variety of other reactions that obscure the picture and prevent her from understanding what this means to the client.

THE SUPERVISOR'S TASK

Here the supervisor has a delicate task. It is not her job to probe into the life of the worker under her supervision, but she must gently help her to separate her own feelings from those of the client. She must bring to her attention the fact that she is reading into the client's feelings reactions of her own, if this be so; or she must help her to recognize her feelings when it happens that she is annoyed at the person whose response is very different from what hers would be under the same circumstances. This calls for imagination and skill on the part of the supervisor. She must first be able to see, through the distorted picture presented by the worker, something of the real behavior of the client; and then she must lead the worker's imagination beyond the framework of her own feelings to the different response of the client, conditioned as it is by his personality and previous experiences.

To this knowledge and imagination must be added a third quality—that of "feeling with" the other person. Knowledge and imagination broaden our un-

derstanding of other people; "feeling with" enables us to sense with surely the emotional tone of the client. Knowledge and imagination tell us that Miss Brown is really suffering, but also that she may either enjoy her illness or have a strong drive to recover; that she may be comfortable in the domination of her aunt or resent it; that she may reach for her sympathy or loathe it; that she may be deeply grieving over her mother's death or feeling guilty because it meant release for herself from an unwelcome burden.

"FEELING WITH" ANOTHER PERSON

To understand which of these things are true we must learn to attune ourselves to the emotional tone of the other person, just as in order to understand a piece of music one must not only attend carefully but also free one's emotions to travel along with the music and get the "feel" of it. This is a skill for which there is greatly varying natural capacity, but I think that the supervisor who herself understands people in this way can help the workers under her to develop their natural capacity by her own example and by constantly seeking to learn through them what the "feel" of a client is.

These three things—increase of knowledge, the working through (or around) the worker's own prejudices and blind spots, and the growth of an ability to "feel with" the client are elements in the development of a capacity to understand the people with whom we are working. Such understanding seems to me basic to any helpful relationship with other people where the effectiveness of our work depends in any degree on the client's interest in making use of us in getting well—in working through his economic, emotional, or physical ills. This understanding is furthermore basic to the next essential of a healthy client-worker relationship, "acceptance"—for without understanding we cannot "accept."

CAPACITY FOR "ACCEPTANCE"

"Acceptance" is a word which has come to have a peculiar significance for case workers. It has been defined as "letting a client behave as he needs to even when his behavior is very different from what the worker's would be under similar circumstances, not only without feeling condemnation but without losing for him as a person a feeling of warmth." I would think that this quality would be of particular importance in the nursing field. Patients must often be disagreeable and petulant, or clinging and dependent, or foolish, or dirty. None of these things is pleasant and yet if the nurse dislikes her patient and has for him no feeling of human sympathy and warmth, my hunch is that she will not be able to work with him or have him work with her in the fight for health.

How does the supervisor help the worker to achieve this kind of feeling for her clients? First and foremost, the supervisor must be herself a person with a broad tolerance for the foibles of people, one who really likes humankind. The worker under such a supervisor has a direct experience of what such an "accepting" relationship means. For she, too, will have her queernesses and weaknesses—some of which she will have to give up or modify in order to become a skillful worker—but if throughout she feels the sustaining support of a supervisor who is understanding and kindly toward her as a person, she will know the value of this kind of relationship and will be better able to regard others in the same way. Beyond this, all the help that the supervisor gives in developing *understanding*—knowledge, imagination, ability to "feel with"—will prepare the way for the worker's growth in her capacity for *acceptance*.

THE LIMITATIONS OF OUR ROLE

Third and last—what of the limitations of our role in a situation? We

social workers have found that we have often blocked ourselves in carrying out our major function in a situation by concerning ourselves with problems that we are not prepared to solve and that we had not been asked to take a part in. The relief worker who attempted, uninvited, to advise the mother on the treatment of young Johnnie's temper tantrums often stirred up resentment that took the form of haggling over the size of the grocery order, and the child welfare worker who entered unasked as mediator into a husband-wife conflict ended many times by alienating the client to such an extent that the parents turned away from her instead of making use of the facilities of her agency. We have learned, I hope, that clients will have many problems aside from those for which they ask our help and many in which we lack sufficient training and skill to be helpful. As we have begun to confine ourselves to work only in those areas in which we have a legitimate function and recognized skill, we have found our relationships to clients immeasurably improved and their response to our ministrations in our proper field of service greater by far.

Naturally, the first essential in teaching this to a worker is that the supervisor herself must have clearly worked through the limitations of the worker's role in whatever field she is engaged. Only then can she help those under her to recognize them also. Further than this, her relationships with other agencies in the community must be such that she can guide the worker in making use of these other facilities in responding to needs which her own agency is not fitted by function or skill to meet. For the case worker this often means calling on the public health nurse; and for the nurse, it should mean asking the help of the case worker. Our professions run side by side. Each has special skills; neither can have more than a superficial knowledge of the

other's field. Only by close teamwork can we see that the client or patient is well served.

There are, of course, many other elements in supervision. I have chosen for discussion understanding, acceptance, and the importance of limiting oneself to one's own function because those things seem to me fundamental in establishing a healthy working relationship with client or patient. If we do not understand, we are apt to do and say things that annoy the patient and cause him to resent our efforts; if we are unable to accept his behavior—to

like him as he is—he feels this keenly and fails to respond to our care; if we try to take responsibility for areas of his life in which he does not want our help or in which we are unprepared to serve, he is rightfully angry (whether he shows it or not) and may offer active or passive resistance to our ministrations. The skillful supervisor must slowly and gently lead her workers on, broadening their understanding, deepening their acceptance, and strengthening their capacity to limit themselves to the area of work for which they are professionally qualified.

INTERPRETING OUR WORK

THE FIRST step in a planned public-relations program should be to determine the direction of one's efforts. What audience are we trying to reach?

Helen Cody Baker, publicity secretary of the Chicago Council of Social Agencies, advised a group of social work interpreters assembled at an Institute on Interpretation held in connection with the New York State Conference on Social Work, "to improve interpretation for the inner circle 150 percent before beginning to bother about the general public."

We had probably better begin with the board and staff, because they are closer to the program than anybody else, and if thoroughly convinced, will be our staunchest allies. Next, the clients need to understand what we are doing and why we are doing it; they can provide excellent testimonials for us. Then come the other audiences: the coöperating agencies, which need to understand our program; the contributors, whose good will is essential; the potential contributors, whose help is needed if the program is to grow; the key people, like

public officials, leaders of citizen opinion, etc., whose support is essential; the social-minded people who join civic movements and who, if convinced of the value of our program in the community, will be influential in its behalf; and the general public, made up of that large unassorted mass of people who read newspapers and listen to the radio, and who are our most casual audience.

The job is its own best interpreter. Wherever it touches, it creates an impression, good or bad. When the client comes in the door, or the board member telephones, the manner of the receptionist or the voice of the telephone girl conveys to each of them some impression of the service. Each of these fleeting contacts contributes to the ultimate attitude toward the work which the person will have.

Interpretation is not something done in the seclusion of the publicity office alone. It is a shared responsibility of every member of the staff; it is inevitable that every person identified with the program will interpret it in one way or another to outsiders.

Shipwrecked!

A breath-taking adventure which overtook this Panama nurse* in line of duty is described in her letter to a friend, which is published with her permission

Panama, February 15, 1938

Dear Becky:

You really should have had a nice Christmas letter, but when I tell you about my December adventure you will understand why no letters were written.

A fortnight before Christmas I started out with three other people on what proved to be an eventful trip, to visit the interior towns of Darien Province, where public health work is being done. The other members of the group were the Assistant Commissioner of Health of the Republic of Panama, whom I shall call Dr. M.; the Rockefeller Foundation representative in Panama, Dr. C.; and the rural instructor in public health nursing, Miss R., who is my assistant. When I packed all my necessities in one small suitcase they all said, "Do you know we are to be gone a week?"

"What I haven't got in that suitcase I'll get along without," I retorted. Everyone else had two or three pieces of baggage.

We had to take a coastal boat, the *Baru*, of the Elliot line. We had a good time on deck singing American and Spanish songs. A Cuban doctor, who is health officer in Darien and who was returning with us from Panama, was the life of the party. He had a good voice and was full of pep. It had begun to rain and we retired at ten o'clock. The men roamed about for a while longer. My companion and I were the only women aboard.

*Johanna J. Schwarte, Chief Nurse of the Service of Public Health Nursing of the Republic of Panama.

We were peacefully sleeping when we were rudely awakened by a terrific scraping and cracking of timbers, followed by a second impact and then a third. The men were on deck in a jiffy and the captain, pale as a ghost, came along and said, "Get life-belts, everybody, and on deck. The *Baru* is gone."

Dr. C. came in and dragged out the belts for us while we put on kimonas over our pajamas and managed to slip into our shoes. Somehow, with life-belts half on, we staggered onto the deck of the lurching ship. Before we reached the rail the engines stopped and the lights went out.

That was a terrible moment! By flashlight the first boat was lowered, and somehow we managed to get into it. Then the other two were lowered. It was pouring rain; the sea was high; and rocks were all around. We had a few thin cotton blankets and a couple of pieces of canvas. We were cold with fear and rain. The life-belts were the warmest attire we had. Our boat remained attached to the ship, and a knife was held ready to cut us loose if the ship toppled over. We didn't dare cut loose for fear we'd be dashed on the rocks all around us. Every few minutes a wave would send us toward the ship and the ship over toward us and we were sure we would crash. But the man at the oars knew his business! Once we did hit and lost a board from the life-boat, but fortunately we didn't know about the board till we reached shore.

The first hour was endless, but after that we got used to our plight. The Cuban doctor alternately prayed and swore. He sat in the boat in the only

position to bail. The crew had to take to the boats soon after we did, for the ship was breaking up fast. The captain came over into our boat and he brought my suitcase and my companion's small one. He said he dared not risk bringing any more, but he felt so sorry for the ladies in their scant attire. The Cuban doctor was given a bucket to bail with, but we were so crowded he couldn't handle it, so he used his shoe. After a couple of hours, a flashlight which someone turned on him disclosed that he was bailing with a little white enameled "night pot." Nobody was ever able to tell how it got there or when. It made an excellent bailer, however, and literally saved our lives. Every time the doctor would see us heading for a crash he'd mumble a prayer, duck his head, and bail like fury.

Another funny bit happened when the oar of the boat next to us splashed harder than usual, and one of the men yelled at Dr. C., "Look out, Doctor, your coat is getting wet." It had never stopped raining and there wasn't a dry inch anywhere!

Finally, at six-fifteen came a slow dawn, and none too soon. We cut away and put out to sea just in time to see the *Baru* heave over on her starboard side. We got terribly seasick, but we were glad to be riding the waves, out of the dark and away from the rocks! An hour and a half brought us to the beach and we found ourselves in a little forty-family settlement, called Gonzalo Vasquez—all black folks, and so kind and hospitable. They took us to the largest house, that of the school teacher. In about half an hour she had dry clothes for everybody, and hot food. I supplied my companion from my suitcase, for her little bag contained only her toilet articles. Her clothes were all in the large suitcase left on the ship.

The *Baru* had no radio. Gonzalo Vasquez had no telegraph nor telephone. We waited for a passing boat that came along about noon which was signalled

and given messages to send from the nearest port. The stormy weather delayed the boat and she reached La Palma at nine p.m. instead of at five o'clock. There was no telegraph there, so the governor himself started out immediately for the next town, El Real. He travelled all night and most of the next morning, and the first that Panama heard of our plight was on Friday noon—the wreck had occurred Wednesday night.

In the meantime the women pounded out rice all day, and sacrificed all available chickens to feed us. With hard tack, some bread, a few cans of food from the ship, and plenty of cocoanuts we were fed. The captain and crew went back to the ship but found her pretty well gone and all baggage and furniture washed away. The little food, the ship's log, and a lot of cigarettes were all they found and brought back. It rained incessantly, and we were continually damp. When it wasn't raining too hard, we strolled along the beach.

At night three of us—my companion, Dr. C., and I—shared the beds with the family. Two cots and a hammock took care of Dr. M., the Cuban doctor, and a Panamanian government man who was a passenger. The rest slept on the floor.

I wish I could sketch the picture of us all sitting around in the hut! The captain and officers, who were blonde Swedes; the three doctors, sun-tanned; and the others from every shade of brown to deepest black Panamanians—all sharing food, clothing, and shelter in the friendliest way. Twenty-eight in all, passengers and crew.

On Friday morning we were cold and restless, and also sticky—for the natives had to carry all their water and our morning toilet was made with a small glassful. The beach was lovely and safe, so my companion, Dr. C., and I decided to try a swim. Señora Andrade, the school teacher, said she would go with us. We three women went native

fashion, in our dresses. All of the children and young boys in the place joined us. We couldn't get a recruit from the other passengers or crew, but we had a grand swim in the sea with all our black friends. Then, with soap and a single towel, they took us on quite a walk up a rocky mountain stream to a lovely waterfall. At the base was a swirling pool large enough for four people. The strong black men led us in. We soaped discreetly, hair and all; got a grand rinse; and sat on the rocks and passed the soap—which belonged to my companion—around to our black friends. It was nicely scented and what a treat to them all! Since it was still pouring, we got a second rinsing with rain-water. But after a rub-down and putting our clothes on again we felt warm and clean and ready for *arroz con coco* (rice cooked with cocoanut milk.)

On Friday afternoon a delegation of twenty men arrived in the rain, after travelling all day from La Palma, walking with heavy baskets full of supplies for us. In the party were the native governor, the chief of police, the school inspector, and all the men who carried the packs.

No children were ever more anxious to see what Santa Claus had brought. We all crowded around while they produced wonders from the baskets. They must have cleaned out the stores. New cotton pants, shirts, underwear, and even handkerchiefs for all the men. All kinds of canned foods, crackers, butter, cigarettes. The nurse had sent her best clothes, a towel, and a blanket for my companion and myself. So that night the teacher served supper to forty-eight.

On Saturday at ten a.m. a boat brought word that the *Chiriqui*, the newest and largest ship of the line, would be there about eleven o'clock to pick us up. It is too large to make any small port, so we had to put on those blessed life-belts again and ride the waves in the life-boats to a small freight-boat which had orders to circle

around until the *Chiriqui* arrived. We circled for two hours and it became rougher and rougher. The waves swept over the decks. It was raining and there was little covered space. And everybody was getting seasickish.

When a banana boat passed, the captain asked them to tell the *Chiriqui* we were heading for La Palma. About five o'clock we entered the calmer waters of the river and were just in sight of La Palma when the *Chiriqui* appeared in the distance. So we turned around and went to meet her, and transferred much more easily than we would have on the sea. A hot dinner awaited us. The *Chiriqui* looked like the *Queen Mary* to us. The captain asked if there was anything he could do for us. We said we could think of nothing nicer than a pair of dry pajamas and a bunk. So he found two pairs of men's pajamas for us, and after dinner we retired. We slept well until two in the morning, when we reached Balboa.

We really were very lucky; not a soul lost or injured, and no bad after affects from exposure. We all found that we were pretty "jittery" for about a week, not able to concentrate or to write. I tried addressing Christmas cards, but after finding that I had done just four in two hours, I gave it up for a while. The company made a very generous allowance for all personal losses. My suitcase went to pieces from the water and had to be roped together. That, a kodak, and my new Spanish grammar were my losses. So now I belong to the international order of *naufragas*.

We had to go to the court to make our statements. The court is called the *juzgado*, pronounced *hoosgado*. When they say it fast, it sounds like *hoosegow*, and I am told that is where the slang expression originated.

My five months in Panama have given me more unusual experiences than some people have in a lifetime!

Affectionately yours,
Jo.

Common Poisons in Industry

By ELSTON L. BELKNAP, M.D.

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Poisoning by inhalation, though numerically a minor cause of industrial disability, is a grave hazard to the worker who is exposed to toxic substances

POISONINGS are not common in industry. In fact they comprise hardly one percent of the causes of industrial disability. However, in actual cost they may loom large in individual cases, both for the worker and the employer. There are, of course, certain common poisonings of industry. I will mention examples of four general types: (1) lead, an example of mineral poisons (2) "volatile solvents" (3) nitrogen peroxide, a gas, typical of actual irritants causing inflammation of lungs (4) carbon monoxide, an example of chemical asphyxiants which combine with the hemoglobin and prevent oxygen from reaching the tissues.

In this discussion, we must first consider what is the portal of entry—how does the poison get into the system? Second, we will take up detection and recognition, and third, prevention.

Catherine de Médici, the arch poisoner of the ages, used chiefly the gastrointestinal route. Although that was effective in most cases, a much more effective and refined way is our modern method via breathing, or the inhalation route. What are the chances of poison absorption during three meals a day compared with at least eight thousand full breaths in a working day? And further, a good deal of a swallowed poison may be absorbed slowly or may pass through entirely unabsorbed, while all that is breathed in is immediately absorbed and rushed through the system in twenty-four seconds.

The simplest and most common way,

then, to start on this type of detective work is to develop our sense of smell. In fact, we must develop a very "nose for trouble," and by this I mean that all the senses must be trained to be keen. We must have not only an eye for dust in the air and on overhead pipes but also an imaginative or mind's eye that can visualize dust so finely powdered that it really is invisible and almost defies gravity. Lead dust has been known to float in the air for two or three days after a shop has been closed for inventory. Such dust may turn up in the most unexpected places, far from its original sources, carried by hidden air currents and actually causing lead absorption in workers supposedly not exposed to lead. And finally, we must know where to suspect the insidious gas that has no odor or color, such as carbon monoxide.

MINERAL POISONS

The most common poisonous material of modern industry is lead. It is used in more than one hundred and fifty of our industries. I shall name ten of them—the commonest, and those with which I have had actual experience. Heading this list formerly was the storage battery industry, where finely divided lead oxide was generated in clouds, before proper engineering control was evolved. Next in severity of effects is the cutting of lead-painted metal with oxyacetylene torches, which easily volatilize lead into a finely divided fume at a torch temperature of 3000° and over. This occurs

in the scrapping of old iron used to reinforce office buildings or in the dismantling of old ships. Equal in seriousness and perhaps more frequent is the smoothing down of all-steel, welded auto-bodies by grinding them down with machine abrasive wheels over lead-solder paste that has been slapped on to fill up the welding irregularities. Here the engineers have actually had to reverse progress and return from machine-age to hand methods, namely hand filing, in order to protect the worker. With this old method, the particles are so big and heavy that they make relatively little inhalable dust.

Farm work, you may say, is healthful. Well, it is if the farmer uses a respirator when he sprays lead arsenate. Then certainly canning condensed milk is harmless? It is if the hand solderer—often the only operator doing such work in the plant—has adequate suction when he seals up the cans which have been missed by the automatic solderer as they pass by on their way to the conveyor.

Painting you probably think is dangerous. As a matter of fact, relatively it is not as far as lead goes nowadays. For one reason, lead is used much less in paint than formerly. Then, too, it comes in a paste or liquid form already mixed. The old dry mixing of the white lead is almost a thing of the past. With the spray gun, the hazard is intensified if lead is used. Often a substitution of other harmless pigments, such as titanium, has been made, and usually suction booths have been supplied for the spraying. Here, however, comes the never-ending problem of proper maintenance of equipment if toxic substances are used. If there is a break in technique there will be tragic results, just as in the operating room.

We used to fear hand sanding. But now the use of the blow torch for burning off old painted surfaces constitutes a much greater lead hazard.

Certainly the printing trade is a dangerous one as regards lead? Yes, it is,

but with reservations; and then it is dangerous only to a few. With the modern linotype machines, the lead pots are small, hooded, and usually kept at a relatively low temperature by automatic electric thermostats. In stereotyping, it is fortunate that if lead gets too hot near the volatility level the paper mats are apt to be burned. So economy forces prudence. The printing trade, however, still has a few danger spots for lead absorption. The man who saws and remelts type metal may be exposed heavily to lead oxide absorption unless he is supplied with adequate suction and in some instances even a positive pressure respirator.

Certain medical experts say that there is no lead hazard in handling brass. However, I have found actual proof of lead absorption with gum "lead-lines" and even high stipple cell counts, and disability in men who saw brass or tend brass furnaces. Even though brass may only contain from 1 to 7 percent lead, it is obvious that when lead which volatilizes between 900 and 1000° is put into the melting pot along with copper which melts at 2000°, there must be lead oxide fumes in the air.

Thus I know that experts are occasionally wrong. However, I do not believe they would make such a mistake if they would actually go out into their plants for periodic inspection, in order to understand the actual industrial processes which involve a toxic risk. Among other misconceptions is the story that certain lead compounds are safer than others. I have found that the red and brown oxides, sublimed blue lead, and yellow and green chromates may be actually just as dangerous as white lead.

The last of my ten common lead hazards is found in the small battery repair shops, and finally in the junk yards where batteries are broken up. Or it may even be found in the misguided cases of charity where broken-up wooden railway cars have been given to the poor to burn in their faulty stoves,

thereby loading up their children with lead. Here in the midst of ignorance, real lead poisoning may insidiously flourish.

LEAD ABSORPTION VS. POISONING

I have been discussing incidence and portal of entry of lead—as an example of one type of poisoning. Now I must explain the mechanism of the actual working of this particular poisoning on the human body. Mere absorption of lead into the stomach, or even into the blood and thence into the gums or urine, does not mean lead poisoning. It means simply what it says—lead absorption. This is nondisabling and nondamaging in many instances, for there is a normal and safe lead metabolism. The body can handle and excrete a good deal of absorbed lead without causing any symptoms or demonstrable evidence of systematic damage.

If the absorbed lead floods in, however, in excess quantities, before the body can either deposit it in an entirely harmless form in the bones or excrete it into the urine or stool, there will be lead intoxication. Such lead intoxication with symptoms is really lead poisoning. Thus in lead poisoning we have the terrific recurring pains of lead colic together with its associated anemia, if neglected; more rarely, wrist-drop or foot-drop; and very rarely lead encephalopathy or brain involvement.

How can lead poisoning be prevented? "That is simple," say certain lead experts. "Just prevent lead absorption by keeping the lead in the air below 1.5 milligrams per 10 cubic meters." However, pending the time when this will be possible we must temporize with some of the practical problems of real life and competition. In the interval until our engineers bring on the millennium we must protect our men.

I for one will not take the responsibility for the inability of industry to immediately enact startling reformation.

Although the employer is usually willing it often takes months before practical measures of protection can be worked into production. Meanwhile my business as a physician is to keep the worker healthy. From eight years of experience I know that it can be done by proper medical observation—spotting and stopping lead intoxication long before it occurs. We must not wait for symptoms of constipation and colic, however. That is too late to prevent lead disability.

MEASURES FOR PROTECTION

The details of these periodic physical and laboratory recheck examinations, and the correlation of medical treatment with temporary protection of workers by air-line respirators have been described in an article on the subject.¹ With these measures we can be successful in meeting the immediate need of keeping men healthy and at work while exposed to a decreasing amount of lead absorption. This plan requires medical training and must be left in the hands of the plant physician. Only thus can we have practical control of lead poisoning in the worker at work.

However, all personnel in the plant—whether plant nurse, foreman, or executive—should understand that operations involving lead dusts are dangerous; that inhalation of this dust is more dangerous than ingestion of poison, as by eating; and therefore, that no tile-lined wash-and lunch-rooms—desirable though they are—can ever take the place of adequate suction hoods or respirators in the plant itself.

The person responsible for the safety of the workers should walk through the plants with a seeing eye, talk with the men, and listen to their suggestions as to possible new sources of lead dust absorption. It is important above all to obtain and keep their confidence by calling a spade a spade. It should be admitted that there is such a thing as lead poisoning, that workers may be

exposed to lead and that they will no doubt absorb some. But it can be explained to them that if they follow orders and coöperate they will probably never be disabled by lead.

VOLATILE SOLVENTS

The second group of poisons which hold untold possibilities for good and evil are those which we lump under the phrase "volatile solvents," chiefly inhalation hazards. There are now upwards of three hundred such solvents available and the chemists are turning them out daily with geometrical rapidity.² This guinea-pig-like evolution of new solvents is taking place almost faster than we can keep pace with it by making enough physiological experiments to determine the toxicity of the solvents. Most of the larger paint companies warn their buyers if they suspect any of their solvents of having dangerous qualities. Some of the smaller companies, however, have rushed out with untested solvents that have caused serious disabilities and even deaths of the users. Employers should demand information as to the contents of all paints and solvents which they use—before a man is disabled rather than afterward.

The old quick-drying solvent which was formerly used widely was *benzol*, an aromatic hydrocarbon. It caused its first widely heralded havoc in this country in a group of girls in an Eastern city in 1910. They used it in a cement to seal tin cans. Many of them developed a relentless aplastic anemia and died. Benzol attacks the bone marrow and thus prevents the formation of new blood cells. It is used safely, however, in instances where its danger is realized and guarded against. With certain simple blood and urine studies, affected men can be singled out early and moved in time to prevent sentence of death. The safe limit it said be to 100 parts per million parts of air for prolonged exposure.

Benzol poisoning is a terrible example

of "murder will out." I was astounded recently to find a plant using it without any suction, and splashing it about like water. I had been told the workers had turpentine poisoning but I insisted on inspecting the plant, as is my custom. No one really knew what they were using until I insisted that they show me their stock tank of the solvent. Finally we found someone who had a key to a dark little supply shack and there in large print on the stock barrel was the stamp *benzol—poison*. The workers, the foreman, and the superintendent did not know what they were using. It was just ignorance, but exactly as dangerous as wilful neglect.

The benzol people are to be complimented that they put *poison* on the barrel. The makers of many other volatile solvents should also be required to label them as poison. Even people in their homes are not safe from benzol, since it is not infrequently used in certain floor waxes and varnish removers. Such work should never be done in a closed room.

Next to benzol come the chlorinated hydrocarbons. They have a somewhat nicer smell and help paints to dry more quickly, but they are likely to be just as toxic. After inhalation they disable and sometimes kill by attacking the liver or kidneys or the nervous system. This effect can be studied by certain liver or kidney function tests. If these chlorinated solvents are recognized as dangerous they may also be used safely with proper precautions.

Carbon tetrachloride is an example of a common chlorinated hydrocarbon. Besides its value as a solvent, it is used in some fire extinguishers and also commonly in cleaning solutions. It is extremely volatile but can be used safely in most commercial inclosed installations. However, do not economize by cleaning your own rugs with it some cold day when all the windows are closed. Furthermore, do not spray it into a closed space on a hot fire if you

have to go in and breathe the hot vapor afterward. If you do, you will probably inhale phosgene, one of the deadliest of the war gases. Under high heat, carbon-tetrachloride breaks down to phosgene as do most of the chlorinated hydrocarbons under such circumstances.

Carbon tetrachloride, like most of the volatile solvents but unlike lead, gives ample warning of its toxicity by symptoms of nausea, vomiting, and headache. When a number of men give such symptoms, it is important to look for the cause at once.

HOW THE NURSE CAN HELP?

Plant nurses can often aid if they will report for investigation any unusual epidemic of symptoms such as nausea or vomiting. I know one nurse who did just this when several men from a certain department kept coming to the first aid room because they always vomited their lunch. These men were exposed to carbon tetrachloride vapors when it was used to clean out pitch from old beer barrels. None suffered lasting injury although several showed a temporary reduction of their liver function. As a result of this one nurse's report with its resulting investigation, the entire operation was changed. Another much less toxic solvent, trichlorethylene, was substituted. Even this so-called "safe" substitute bears watching, however, for no volatile solvent is safe in high concentration. The safe upper limit of carbon tetrachloride concentration is 100 parts per million for prolonged exposure. This is the concentration just perceptible to the average nose.³ The safe limit for trichlorethylene is 250 parts per million.

An even more dangerous example of chlorinated hydrocarbon is the ethylene dichloride which has been used rather widely in the coating of beer containers.⁴ Not long ago I had an instance of this particular solvent which illustrates not only its toxicity but how such a dangerous substance may creep into use in a

factory where there are responsible personnel who think there is no actual hazard.

A worker developed nausea, foot-drop, and vague abdominal symptoms associated with some liver damage. The officials assured me that this man did not spray the ethylene dichloride and on actual investigation in my own survey of the plant I found that he did not. After discussion with him, however, and verification upon conversation with the foreman, I found that for 30 to 45 minutes a day he used to clean his spray gun by running what he called "chloride" (ethylene dichloride) through it, splashing into an open pail directly beneath his face, ideal for inhalation. Then he would feel very happy and almost intoxicated, wishing to sing and whistle rather wildly, and finally vomiting as if drunk.

Our emphasis must be on predicting every unsuspected break in technique when we are handling potential poisons. Practically every toxic substance can be handled safely and must be handled if modern industry is to progress. It means unceasing vigilance on the part of the engineer, the foreman, the workers, and the plant nurse and doctor to ferret out and control absorption of these toxic but necessary materials.

TOXIC IRRITANTS

In regard to the third type of poisons, toxic irritants, it must be said that the vapors of hydrochloric and sulphuric acid, though they may be quite irritating to the upper respiratory tract temporarily, are quite unlikely to produce permanent damage. On the other hand, the heavy brown vapors of "fuming nitric acid" are very dangerous. I always insist that nitric acid used for bright-dipping of parts for plating be given adequate suction or exhaust. Such a gas as peroxide of nitrogen, probably also evolved from welding in an enclosed space, may choke and kill with acute pulmonary edema after a treacherous latent period of several hours—just as did the fumes of the burning x-ray film in the Cleveland clinic disaster. The safe upper limit of the nitrogen peroxide

for prolonged exposure is 40 parts per million.⁵

CHEMICAL ASPHYXIANT

For the best example of the fourth group of poisons, namely the chemical asphyxiant—which acts by combining with hemoglobin and preventing oxygen from reaching the tissues—we have carbon monoxide. Many regard this as the commonest of industrial hazards.⁶ It acts by anoxemia, depriving the tissues of their oxygen. The so-called safe concentration is 100 parts per million. Carbon monoxide is really odorless, so our noses can not be indispensable here, but it usually occurs where we do smell and see smoke of incomplete combustion. This gives us the hint that where there is smoke, carbon monoxide is likely to be found. In fact we must suspect carbon monoxide wherever there is a flame, particularly where the flame strikes a large cool surface as when gas-fired boilers, pots, or molds are first fired up in the morning. Gas itself, especially if it is water gas, contains considerable carbon monoxide. So one should be aware of the make-up of the gas supplied.

In this fourth group it will pay us to give immediate heed to certain complaints of workers. When a worker who is exposed to a flame or even fumes from blasting complains of tightness across the forehead, headache, weakness, dizziness, or palpitation of the heart, we must get him into fresh air immediately. If we suspect carbon monoxide we should obtain blood samples and send them to the hospital laboratory. If we wait for nausea and vomiting, in a few minutes there will be collapse and then unconsciousness. While unconsciousness does not spell immediate death, the longer we postpone getting oxygen to the patient by inhalator together with artificial respiration, the more likely we are to have real central nervous system residuals, if not death itself. Of all four groups of poi-

sons, carbon monoxide presents the greatest need for rapid, well trained action.

A young man had to do prolonged and heavy work in an enclosed space exposed to carbon monoxide. Towards the end of his tour of duty he became nauseated as did other workers, but he kept on by sheer will power although the others went out into the fresh air and vomited. On leaving work he was confused and very drowsy so that when he reached home in a companion's car he had to be carried up and put to bed. Because no one was aware of his condition he was allowed to remain neglected, semiconscious in his room, for the next 24 to 36 hours. Then he was taken to a hospital and finally given oxygen therapy. This is an excellent example of how not to handle such a case, because here the young, susceptible individual was kept at exertion exposed to continued doses of carbon monoxide. The stage of beginning intoxication with headache and nausea was overlooked because of his own persistence and the ignorant neglect of his companions. As a result he had a lesion of the brain. This caused terrific bouts of unbearable pain that required actual anesthesia to give relief.

This is fortunately a rare instance because usually when carbon monoxide cases become unconscious they either recover without symptoms or have a fatal termination.

To prevent such carbon-monoxide intoxication or poisoning, we must foresee first that any flames without ventilation are dangerous; second, that youths and the very old or anemic individuals are most susceptible; and third, that exertion after the exposure predisposes to more serious complications. We all know that this asphyxiant can kill in heavy doses, but just how much damage small, repeated doses do has not yet been fully worked out.

ETERNAL VIGILANCE NECESSARY

This description of common poisons of industry may sound appalling but we must have a deep respect for the worker who braves such risks and for the thoughtful executive—and there are many such—who bends every effort to protect his men. Because much of mod-

ern industry involves the use of chemistry, we do need more caution in industry before attempting new procedures. None of these should be put into production before the medical department is consulted as to possible toxicity. A frank warning to a worker regarding dangerous substances with which he may have to work is essential. If he knows that the chief danger is by inhalation, then he can coöperate intelligently in using protective devices supplied.

Medical preëmployment and periodic recheck examinations should be encouraged to rule out any existing disease which might aggravate or be aggravated by the hazards of industrial exposure. Each alert industrial nurse and lay worker must report immediately when men from certain hazardous departments begin to complain of even slight symptoms such as weakness, headache, nausea, or abdominal distress. While this vigilance is necessary for the recognition and control of the four examples of poisons that have just been considered—namely, lead, volatile solvents, nitrogen peroxide fumes, and carbon monoxide—it is just as true with hundreds of other toxic hazards. Finally,

every effort should be made to correlate engineering and chemical analyses of hazardous operation with the clinical judgment of the physician in charge if we are to help industry progress by preventing damage to that most complex and valuable of all machines, the human body.

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Let's Coördinate

BY MAE A. BROWN, R.N.

Department of Health, County of Westchester, Tarrytown, New York

A county nurse and a school nurse work out a plan of co-ordination which results in better service to the community

A CHILD HYGIENE clinic for well babies and preschool became the first step and the major factor in the working out of a joint program between the school nurse in the village of Elmsford, New York, and the nurse from the county health department who carries on the generalized program in that village.

It happened in this way. When the community house where these clinics had been held closed its doors, the principal of the grammar school saw possibilities for better coördination of the health services of the community. He invited the county nurse to use the cafeteria rooms in the basement of the school building for the clinics. The place, while inadequate in some respects, is clean and attractive. It has running water and generous table space, and is accessible to the mothers of the village.

THE SCHOOL'S FUTURE PUPILS

The principal is interested in our clinical findings—not only regarding physical defects, but our observations of whether a child has the ability to dress and undress himself, put on rubbers, and mingle with other children, and whether he shows self-reliance in general.

The fact that we are actually in a school building provides a setting which helps us to show the mother the relationship between the child's food habits, toilet habits, and ability to be independent, and his adjustment to school life.

The preschool child's own reaction is interesting. Usually, he is anxious to

start to school and participate in the activities which he has caught glimpses of. When the nurse or doctor glances over his chart and says, "It looks to me as if you will need to eat more vegetables or fruit," or "Do you think you can eat more eggs if you are allowed to start to school in September?" the child often has a better incentive for good health habits than he might otherwise have had.

The school principal expects to make use of the preschool record of habits, abilities, and physical condition of the child in helping to place him in the proper grade in school. This placing has formerly been done entirely by means of mental tests.

The doctor who examines the babies and preschool children also shows an unusual interest in the educational aspect of the program as it is developing. His plan is to examine all the children who do not attend clinic regularly, one year before they enter school. He will follow this examination in six months by another one, to determine what improvement in habits or physical condition has occurred. So far, no plan has been made for a similar examination of children under the supervision of private physicians.

Another factor which contributes to the coördination of the program is the fact that clerical help is provided to both nurses by the National Youth Administration workers located in the high school. For example, when these workers send out appointment cards to parents regarding attendance at child hy-

giene clinics, the school nurse looks over the cards. If she wishes to see any of the mothers she adds a postscript.

PLANNING TOGETHER

Another activity in which both nurses work together is that of our immunization clinics. Previously, the county nurse mailed cards or letters to parents explaining the purpose of the clinic, and the school nurse sent home mimeographed sheets for the same purpose. Many mothers received both.

We have now prepared a statement listing all the children in a family, and showing what immunization treatment has already been given and what should be given. When this statement, signed by both nurses, is mailed to the parent it shows the interest of both in all of the children in the family.

In the high school our program is still in its early stages. Chest clinics are held twice a month. Since both nurses take part, each one has an opportunity to know the family as a whole. Our policy of follow-up is this: When a diagnosis of tuberculosis is made, the county nurse is responsible for visiting the home and seeing that recommendations are carried out. When no tuberculosis is found in the family, the school nurse is responsible for the health supervision of the school children, just as she is in any other family.

In all instances we plan our work together as much as possible so as to eliminate overlapping. The nurse who goes into the home first takes care of all problems in the family, if possible.

In the high school building we have a new dental chair and equipment which are intended for both school children and preschool children. The dental program for the school children is under way, but so far it has been impossible to start the preschool program—although \$200 has been appropriated for this purpose. We are now promised another worker from the National Youth Administration who will receive training as a dental hygienist and who will assist the dentist, full time, so that both nurses will be free to carry on other work.

An interesting contribution made by the high school to our work was the suggestion of Italian recipe books containing Italian dishes and using canned milk. This was done after the teacher learned the difficulties that the nurses had in getting Italian mothers to use canned milk—even when the family was on relief and a part of their allotted milk supply was canned milk.

The Westchester County Department of Health has an affiliation with a university whose students are coming to the service to secure field experience and to study various phases of the health program in the county. We also have demonstration programs that are carried on for various purposes. These projects give the school nurse and the county nurse new incentives for coördination so that their efforts may mean more to other individuals and organizations, and they in turn are better able to share what other individuals or organizations have to offer.

Take one large, grassy field, one half-dozen children, two or three small dogs, a pinch of brook, and some pebbles. Mix the children and dogs well together and put them in the field, stirring constantly.

Pour the brook over the pebbles, sprinkle the field with flowers, spread over all a deep blue sky, and bake in the hot sun. When brown, remove and set to cool in the bathtub.

—*Garden Club.*

A Public School for the Crippled Child

By MILDRED MEADOR

Principal, Randall J. Condon School, Cincinnati, Ohio

A visit to a public school for crippled children where the curriculum is an activity program based on the needs and interests of the children

ONE SCHOOL has been set aside by the Cincinnati public school system for the education of its crippled children. Originally called the School for Crippled Children, it was renamed the Randall J. Condon School in honor of a former superintendent of schools whose interest and enthusiasm were largely responsible for the beautiful two-story buff brick building which now houses the school.

The educational work of this school is based upon the underlying principle that we learn by doing. Throughout the school an activity program is carried out in which children's interests are the basis for the selection of the units of work.

Perhaps you would enjoy a visit to the school. Let us take a ride in the big blue bus with the children. It is 7:15 in the morning. Our bus pulls out of its parking place and starts its rounds. Soon we see a little boy standing on the corner. He climbs into the bus with great speed in spite of a crutch and an artificial limb. A little farther on we stop for Fred. His father comes out of the house carrying him, for Fred has had poliomyelitis and has not yet learned to walk. Soon we pull up close to the curb. The driver hurries into the house and carries Julia down the steps and into the bus. Carefully he places her on the seat of the bus and fastens a belt around her waist. On again, stopping for Marie, who has a tuberculous hip; for Geraldine, a car-

diac patient; for Jim, who has lost his leg in an accident; and so on until all twenty-five have been picked up.

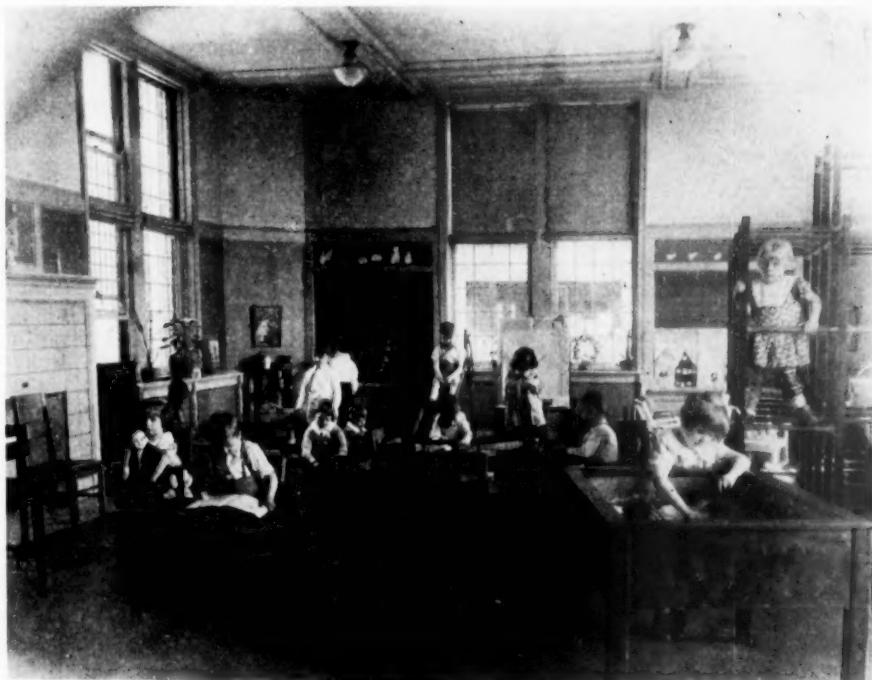
And now we turn on Rockdale Avenue, drive into the big garage back of the school, and unload the boys and girls. Soon all nine buses have arrived and school work begins—the same kind of school work that all the other sixty thousand boys and girls in the Cincinnati public schools are doing.

BUILDING ADAPTED TO NEEDS

The building is especially well adapted to the needs of handicapped children. Two electric elevators connect the floors. In addition to the classrooms, library, auditorium, offices, and special departments there is a radiation room, rest room, two suites for the medical staff, kitchen, and dining room. Plans are now under way for the installation of a therapeutic pool in what is now the playroom.

Perhaps you will visit the kindergarten where you will see these little folks working with clay, paint, or crayons, playing in the sand table, climbing the junglegym, or gathered in a circle talking about the food they eat.

In the second grade a transportation unit is in progress, and the boys and girls are enthusiastically planning for a trip which they will take in the near future. It will be necessary to take two wheel chairs but this can be accomplished easily. There are small wheel chairs which will easily fit into the



Little folks are busy with interesting activities

school bus that will transport the children to the railroad terminal. (Even the big boys and girls in the eighth grade use these chairs when they go on trips.) They will then board the train for Winton Place—a suburban railroad station—a ride of only twenty minutes in reality, but filled with so much of interest that it seems many miles to the boys and girls. They will see all the different parts of the train—the diner, the Pullman, and the observation car—and as they ride along they will see many places about which they have talked.

The third grade children are studying about our own city and are interested in the kind of houses in which we live, the kind of clothing we wear, and the kind of food we eat. These children have visited a lumberyard, a brickyard, and a dairy, so they are beginning to understand about the places from which we get our materials and supplies.

In other groups you will find children learning about people of foreign countries, how our forefathers lighted their homes, or what games were played by children of other days.

INTERESTS OF ALL CONSIDERED

Visits to special classes and departments will show that the children have a wide range of opportunities in which interests such as weaving, art, music, construction, and household arts are guided to satisfying achievements.

When the noon hour approaches, everyone gathers in the lunchroom, where an excellent meal is served for ten cents a day. All who are able to pay do so, and meals for the others are provided through contributions from friends of the school. Both before and after lunch there are outdoor play periods for different groups of children. They engage in various adaptations of baseball, football, marbles, hopscotch, catchers,

and various other games suited to their interests and physical condition.

PROGRAM BASED ON NEEDS

But as modern education adapts itself to the needs of the children, so the curriculum in the school for crippled children is adapted to their needs. This necessitates a program that emphasizes not only the educational growth but also the physical welfare of the child. Each morning during the school week a pediatrician comes to the school; two mornings a week, an orthopedic specialist. A heart clinic is conducted at the school each Monday morning under the auspices of the Heart Council of Greater Cincinnati, which sends its nurse and heart specialist for a check-up of children with cardiac disabilities. A dental clinic is held at the school three mornings a week for those children who are unable to go to a family dentist.

The Board of Education employs a full-time school nurse for the school. Her program includes, beside resident work, a public health program in behalf of the families of the children. She visits prospective candidates for the school and arranges for all clinical and hospital appointments. Each year the pediatric department gives a thorough physical examination to each child, and again in the spring a check-up is made. In the transfer of children from this school to another, the nurse becomes the contact person between the two schools as well as between the school and the family.

In the pediatric department you may see a child being given a thorough examination by the physician. Or it may be that a child has been sent to the department by the teacher because he seems to have a cold. This is one of the many evidences of coöperation between the medical staff and the teachers in the school. There is a noticeable lack of coughing and sneezing which is due to the alertness of the teachers in referring children to the health service.

The teachers are instructed in conferences with the physician and nurse to observe early symptoms of colds and other communicable diseases. The early exclusion of these children for a short period of time helps to keep down the respiratory infections so prevalent in other schools. There are many other services offered by the medical staff, such as yearly testing of vision and hearing, the fitting of glasses, the daily checking of temperature and pulse of each child with a cardiac condition, and the arranging of rest periods for the children. A file is kept of each child, which includes a complete record of all examinations and recommendations for treatments.

PHYSICAL THERAPY

In the orthopedic department there are three physical therapists whose entire time is spent in treatment. Each child with an orthopedic disability is assigned to one of the physical therapists for treatment, check-up, and follow-up work. All treatments are prescribed by the child's private physician, the clinic physician, or the school orthopedist. On the two mornings when the doctor comes, this department is turned into clinics for those children who are in need of reexamination. At other times the physical therapists are busy with individual treatments. Some group work is also done with spastic-paralysis cases. The physical therapists keep in direct contact with the physician. They accompany the children to the clinics, to which they are transported by the school bus.

Special apparatus has been installed by the Board of Education so that children may be given the benefit of whichever type of treatment is most beneficial to them. On three mornings a week during the winter months, general radiation is given to children with tuberculosis, malnutrition, osteomyelitis, and others for whom it is prescribed. Individual treatments are also given with a

mercury-vapor lamp. In addition to this, diathermy, infrared treatments, baking, massage, muscle training, and remedial exercises are also given.

Each child's general condition is watched carefully and every consideration is given him to help him adjust to the world in which he lives. At present the department is giving treatment to 135 children with orthopedic conditions. Fifty-two of these are individual treatments, 18 are in classes, and the rest are receiving radiation. Of these 135, 37 are poliomyelitis cases, 23 have tuberculosis, 5 osteomyelitis, 31 spastic paralysis, and 39 miscellaneous conditions.

TEACHING IN THE HOMES

The educational work does not confine itself to just the children in the school. It stretches out and touches the children in the home. Two public school teachers serve full time in the city general hospital. They go from ward to ward, and from bed to bed, giving these children regular school work. The same arrangement is made in two private institutions—the Children's Hospital, and the Children's Convalescent Home, in each of which two teachers are provided by the Board of Education. Besides the teachers in the school itself and in the hospitals, there are seven teachers who go into the homes to teach children with orthopedic and cardiac disabilities, and epileptic children who are unable to be transported to the school.

By means of this tie-up between the various departments of the school it is

possible for a child to receive schooling from the public-school teachers at the Children's Hospital or General Hospital, and then if he is sent to the Children's Convalescent Home he will continue his work with another teacher. The doctor may feel that a few months at home are necessary, and here again a teacher continues his school work.

At the end of several months he may be well enough to go to school but is still in need of a protected environment and so he comes to Randall J. Condon School. As soon as he has made his maximum improvement and can attempt an adjustment in a regular school he is transferred. For two or three years, depending upon the condition, he is called back to the special school once or twice a year for a check-up in regard to his condition.

* * * *

It is three o'clock; the bell rings for dismissal. The children go downstairs on the two electric elevators to the garage where the nine buses are waiting to take them home. We pull out of the garage and start the homeward journey. Tomorrow will be another school day and all of us will be on the job ready to help these boys and girls who will be in a few years the citizens of our city.

EDITOR'S NOTE: This is the second article on the education of handicapped children in special schools. (See "The Education of Handicapped Children," by Bess R. Johnson, April 1938 issue, page 261.)

In order to present different points of view on this subject, these articles will be followed by two articles in early issues discussing the social and psychological values of educating handicapped children in the regular schools.

Two anxious pairs of eyes peeping over the edge of the table, while the baby had its first bath, became perturbed when they saw the cord dressing. "Nurse," asked one of the children, "has our baby been in an accident?"

—*The Visiting Nurse*, Detroit Visiting Nurse Association.

How to Conduct Meetings

Some important points to remember in conducting a meeting correctly and effectively are outlined here

HOW SHOULD board and committee meetings be conducted? What are the responsibilities of the secretary of a meeting? When is a motion necessary, and when can things be decided by consensus? How can the leader of a meeting stimulate discussion by the group? These and other frequently asked questions were discussed at an interesting institute on meeting procedures held under the auspices of the Department of Volunteers in the Council of Social Agencies in Rochester, New York, on March 15, 1938. About 47 persons attended the institute, which was led by Elizabeth J. Mundie, director of Region II, National Field Staff, Girl Scouts, Inc.

Since many of the problems discussed are of interest to our readers, we are summarizing here some of the highlights.

The Department of Volunteers was cited as an example of a change in feeling of individuals toward their organizations. In the past, people tended to emphasize their own agency. Now they are thinking in terms of the community first.

There are three ways of measuring whether a committee is working effectively:

1. Is the committee truly democratic?
2. Is it efficient?
3. Is it contributing to the information and understanding of every member?

CONTENT OF MEETINGS

The agenda is the planned program and is the most important part of the meeting. It is prepared by the executive and chairman in advance. Usually the minutes of the last meeting are used

for reference. If possible, the agenda should be typed and given to everyone before the meeting begins. It should contain the name of the committee, the place and date of meeting, and the name of the presiding officer. The recommended form is as follows:

1. Minutes of previous meeting
(Occasionally, introduction of guests)
2. Treasurer's report
(Occasionally, roll call)
3. Staff report
4. Old business restated and discussion continued
5. New business
6. Other items of business (a good agenda allows for this)

THE SECRETARY'S JOB

The secretary's contribution to the meeting is an important one. Large groups need both a corresponding and recording secretary. Smaller groups combine all duties in one office. The secretary's duties are:

1. He (or she) sends out notices of all meetings.
2. If in a position to do so, he sends the agenda and the minutes of the previous meeting to the president and to those absent from the last meeting. This protects the committee from misunderstandings.
3. He keeps the minutes, taking full and accurate notes. The procedure in large meetings is quite formal and therefore less difficult to report than in small committee meetings where there are few motions, and where much is done through consensus. The secretary needs to be logical, and to be able to correlate. In writing the minutes, he should gather together all the discussion on one subject and try to report it in relation to the items on the agenda.

The secretary reads the minutes to acquaint the group with what went on and to open them for correction. If he objects to a correction, a vote must be taken. In recording motions, it is necessary to record the name

of the person making the motion, but not the name of person seconding.

The group was warned against stifling meetings by sticking too closely to Roberts' "Rules of Order."

MAKING A MOTION

A few rules of parliamentary law were discussed, and it was pointed out that there must always be a motion on:

1. Recommendations
2. Finance
3. New policies

The rest can be done through consensus. There is no need for formal motions on every committee report. If a motion seems to be lost in discussion, it is the secretary's duty or anyone's privilege to call attention to the fact that there is a motion before the house.

The seven steps in a motion are: the introduction, the making, the seconding, the restatement, the discussion, the question, and the vote. An amendment to a motion must be definitely stated. It will be either an addition, subtraction, or insertion. The amendment is voted on as a motion.

INDIVIDUAL AND GROUP THINKING

It was brought out that our thinking can be improved by various methods, such as by keeping well; learning the conditions under which we get good ideas and trying to utilize them; being willing to see through the obvious; learning by experience; increasing our significant interests, thus giving exercise to the thought processes; developing the power of analysis; and watching out for personal bias, and the effect of emotions on opinions and points of view. It is important to realize that everyone has a bias.

DISCUSSION METHOD

Any kind of participation is good. There are two types of discussion: The

first sets out to *create action*, and the subject is usually of a controversial nature. The second is really *analysis*, and a conclusion is not expected.

The leader's job is to understand the group, and to keep the discussion going; he should be able to summarize points at issue and to turn the discussion from one thing to another. The leader should remain objective, and should have accessibility to authoritative material on subjects under discussion.

The technique of having someone ready to disagree keeps a discussion from dying out. The too early settling of a matter is unfortunate. A small group is best for discussion. The chairman needs to have informal meetings, to make the group feel responsible, and to ask *why* frequently. He will find it helpful to call on people by name for their opinions. He points out the progress of the meeting, summarizes, quiets the insistent talker, and keeps the meeting on the track. The length of a meeting should never be more than two hours at the most. Discussion leadership should be sincere and should not be made a means of propaganda.

The following questionnaire suggests problems and situations which arise in group discussions:

1. How could you tactfully stop a person from talking on a "pet" issue?
2. How could you stop a person who continually talks too much?
3. How could you encourage a person who talks too little or not at all?
4. How could you deal with a person who has very set opinions and refutes all contrary opinion at great length?
5. How could you satisfy a person who wants his problem solved quickly and without question?
6. How could you check needless repetition?
7. How could you stimulate a "dead" group?

E.K.D.

How Would You Answer These?

Some suggestions in answer to the questions on varicose veins published in the July issue are given below. You will be interested in comparing your own answers with these, which were supplied by the Maternity Center Association, 1 East 57 Street, New York, N. Y.

1. and 2. *What are varicose veins, and what causes them? What changes occur during pregnancy which tend to increase the discomfort from varicosities?*

A varicose vein is defined as an enlarged and tortuous vein. (W. A. Newman Dorland. (Ed.) The American Illustrated Medical Dictionary. W. B. Saunders Company, Philadelphia, 1937. Page 1484.)

Varicose veins are caused:

1. By constitutionally defective valves in association with postural strain, usually of occupational type, or by

2. Any condition which obstructs venous blood flow over long periods of time, especially pregnancy and pelvic or abdominal neoplasm. The veins are distended and tortuous while chronic venous stasis produces local edema, stabbing or aching pain, indolent ulceration, overgrowth of connective tissue, and, occasionally, hemorrhage or ecchymosis. (Russell Cecil. Text book of Medicine. W. B. Saunders Company, Philadelphia, 1937. Page 1193.)

Pregnant women have a marked tendency to develop varicose veins of the lower half of the body. . . . The usual sites are the legs, the vulva, the mons, the pelvis, the rectum, the anus, the vagina, the abdomen, the buttocks, in the order named. . . . The surface veins are most affected. Of causes, several are given; increased venous congestion below the diaphragm caused by the greater intra-abdominal tension of pregnancy; disturbed vasomotor conditions; increase in the total amount of blood,

and enlargement of the veins to accommodate it; congenital anomaly of veins brought out by pregnancy; a toxic alteration of the blood and vein wall.

Predisposing causes are: thin walled veins, heart disease, tight girdles and garters, constipation, carrying heavy loads, frequent pregnancies, etc. (Joseph B. De Lee. Principles and Practices of Obstetrics. W. B. Saunders Company, Philadelphia, third edition, 1918. Pages 108, 109.)

3. *What suggestions can the nurse give to the pregnant mother to prevent or relieve distress from varicosities?*

There should be no circular constriction at any part of the body, especially no round garters, corsets, or tight waistbands. . . . The feet should be kept off the floor as much as possible, and rubber stockings or a flannel bandage worn during the day. A flannel bandage does not do any good unless well applied and kept in place. . . . The foot of the patient's bed should be elevated eight inches to relieve the engorgement during the night, and each evening and morning the patient should rest her limbs on an almost vertical support (the ironing board) standing against the head of the bed. The woman should be cautioned against injuring the enlarged vessels by scratching or striking against objects, as dangerous and even fatal hemorrhage has resulted. The patient is instructed that should such a hemorrhage occur, she should apply firm pressure to the bleeding point and notify her physician without a moment's delay. (Joseph B. De Lee. Obstetrics for Nurses. W. B. Saunders Company, Philadelphia, elev-

enth edition, 1937. Pages 361, 363.)

A well fitted maternity corset or a properly applied abdominal support may help in securing relief from varicosities when the abdomen is large, relaxed, or pendulous. Such a support can be made at home, using Butterick Pattern No. 9009.* This pattern requires two and one-half yards of unbleached muslin for the larger size; two and one-eighth yards for the smaller size. This support is adjusted while the patient is lying down, the lower border at the level of the symphysis pubis in front, the ends crossed in the back, brought forward, and pinned to the lower margin at the front.

As pregnancy advances, darts must be taken at the right and left front in order to allow sufficient room for the developing uterus and keep the binder snug over the symphysis. This type of binder should fit snugly and should support the abdomen from below.

Free daily evacuation of the bowels secured by a well balanced diet, regular toilet habits, and plenty of fluid intake will help to prevent flatulence and pelvic congestion, and will be a factor in preventing distress from hemorrhoids.

Frequent rest periods with the patient

lying flat on her back with legs elevated will make it possible for the engorged veins to be relieved through gravity.

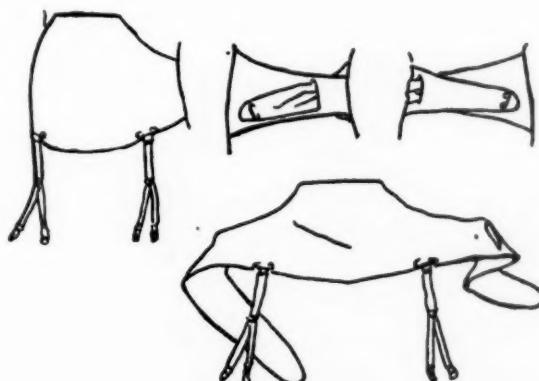
A bandage of the Ace variety is inexpensive and if properly applied will help to prevent congestion and give relief. First, the leg should be elevated to empty the engorged vein. Then the bandage is applied spirally with firm, even pressure, starting with a few turns over the foot to secure it, and—leaving the heel uncovered—carried up the leg to a point above the highest swollen vessels. The bandage should be unwound and completely reapplied if it slips or becomes loosened, since an even pressure is necessary for relief. The bandage should be removed each night and the leg should be bathed.

Some physicians apply wide strips of adhesive plaster over varicosities located at points which are difficult to bandage. If the varicose area is carefully protected by a clean piece of linen under the adhesive plaster, the skin stays in good condition. The adhesive cover helps to protect the part from trauma.

Varicosities of the vulva or rectum are sometimes relieved by lying on the side with hips elevated by a pillow.

Cold compresses applied to the part bring quick relief for painful hemorrhoids.

*The Butterick Company, 161 Sixth Avenue, New York, N. Y. Price 15 cents.



Abdominal Binder

Midwifery Supervision

By ELIZABETH FERGUSON, R.N.

Nurse-Midwife, Maryland State Department of Health, La Plata, Maryland

In southern states with high maternal and infant death rates midwives become important public health agents when they are given adequate preparation and supervision

SUPERVISION OF MIDWIVES is an important part of any program of maternal and infant health in the southern and southwestern states. In the ten states from Virginia south to Florida, and west to Arizona, midwives delivered at least 174,000 babies in 1936 and our highest maternal and infant death rates are found in this area.

It is believed that these high death rates may be attributed in a certain measure to lack of knowledge and skill on the part of the midwife. We should never lose sight, however, of the fact that such deaths are most likely to occur in the poorest economic group of our population.

The state departments of health of these southern states, handicapped by lack of funds and personnel, have for years attempted to license, regulate, and instruct these midwives. Their instruction in many instances has been most inadequate and inappropriate as evidenced by lack of progress and worthwhile results in the actual practice of the midwife. Today, with more public health nurses in the rural areas since the passage of the Social Security Act, this problem is being faced with renewed determination. Instruction of the midwife is of primary importance, because supervision, without an adequate understanding on the midwife's part of what she is doing and why, is valueless and a waste of time.

Some of the experiences gained in supervising midwives in a demonstration area in Southern Maryland over a

period of two years are described in this article.

The difficult task of instructing this poorly educated, usually illiterate individual engaged in the practice of obstetrics requires all of our knowledge of the art of teaching. It is not easy to instruct her. However, if done according to the best practices in education which we know today, we often can secure surprisingly good results.

One element necessary for the success of this program is that the instructor know obstetrics thoroughly. She must know more about it than these midwives who have had years of practice in which they have gained considerable knowledge.

KNOW GROUP TO BE TAUGHT

In teaching any group we first become familiar with their background and characteristics; we determine their potentialities for learning; we consider the grade of material to be presented; and we plan our subject matter on the basis of these factors. The ways of presenting the material to be learned must then be carefully considered.

The average southern midwife learns slowly, and she learns best from demonstration instead of from books or from merely hearing facts told once. She learns easily through imitation and through the simple presentation of vital material.

Her sense of the dramatic is keen, and the most effective teaching is that in which willing patients in the classes and

in the home are used for demonstration. The fact must not be disregarded that the midwife has no understanding of the anatomy and physiology of the human body, of bacteriology, and of bedside nursing skills—all of which are included in a nurse's background before she commences the study of obstetrics. The midwife's vocabulary is small, and although she will learn many new terms they are acquired slowly.

Some of the midwives will readily grasp everything that is presented. Others will be slower and will require frequent repetition of all subject matter. About one fourth or one fifth of any group—depending largely on their age and general intelligence—will probably get little of what is taught. The midwives learn best in small groups of from four to six. If possible, the slower ones should be taught together as their material will have to be more elementary, and those who learn quickly soon become impatient if kept with the slow groups.

USE NONTECHNICAL LANGUAGE

In teaching the science of obstetrics a simple explanation of the principles is made in terms which they can understand. A midwife must learn the different positions of the fetus *in utero*, but they are not designated as *left occipito-anterior* or *right occipito-posterior*. Instead, it is explained that the baby lies with its back to the mother's left side and toward the front of her abdomen. The transverse position is designated as a baby in crosswise position. At the same time that these positions are being explained, they are being demonstrated with a fetal doll and pelvis. The midwives review this lesson with one another by covering the doll and pelvis with a thick cloth while they try to determine the position.

Midwives visit antepartum clinics and do abdominal examinations on their patients. Case histories are presented—such as a case where the fetus was in the

transverse position and the midwife neglected to send for medical assistance; the mother died from exhaustion.

It was not long after one of our class sessions that a doctor told me the following story: One of the midwives in his district sent word that she had been called to deliver a patient and found the baby in a transverse position. "I went down there," he said, "and found that the midwife was right. We sent the patient into the hospital immediately."

We have found that the midwives' powers of observation have been developed more by the use of visual material and demonstrations than in any other way.

WHAT SHOULD BE TAUGHT?

In determining the type of information to be presented to these groups, it has proven satisfactory to develop material which a child of about twelve years could understand. The teaching of nursing procedures to the midwives is not enough. They are engaged in the practice of obstetrics and an understanding of its fundamentals is required. It is necessary, also, for them to know the relation of the parts of the body before a detailed study is made of any one part. An understanding of antepartum complications makes the midwife an enthusiast for antepartum care for her patients.

It has been found in dealing with these groups that extraneous material and many details only confuse the learner. Subject matter must be confined to the minimum essentials and these must be understood and mastered. For it is far more important that a midwife know the four things to do in case of postpartum hemorrhage so well that she can act automatically than it is for her to know the names of the pelvic bones, or where the liver lies in relation to the stomach.

Strict regimentation in regard to equipment is not of primary importance. Whether a midwife carries a black or

brown bag, whether she wears a white or colored wash dress, or whether her scissors cost ten or fifty cents are not matters of great consequence. But the proper preparation of the patient, the use of clean towels and pads at time of delivery, the aseptic care of the cord, the nursing care of the newborn and of the mother, and the use of medical services when indicated are things about which a very firm stand can be taken.

The ways of presenting teaching material depend largely on the midwives' ability to learn. Especially helpful in teaching are motion pictures, drawings, and illustrations in books; manikins and a fetal doll and pelvis; and, wherever possible, actual patients. Visual aids are particularly useful to illustrate adequate antepartum examination, evidences of disease, results of unrepai red lacera tions, the home delivery set-up, and the care of the mother and baby.

Antepartum clinics offer good teaching opportunities for midwives. They learn to use demonstration material, such as equipment for home delivery, in teaching their patients. They can assist in the running of the clinics and observe their patients.

The classes of instruction for midwives usually take about fourteen hours, and are conducted in one-hour sessions covering a period of at least three to four months. Upon completion of the course the midwife is given a printed summary of the class material which she can review and study for the examination.

A nurse who approaches the problem of teaching midwives finds an ideal teaching situation. They are interested in and desirous of learning. The material learned is extremely practical and immediately useful, and they are rather proud of a knowledge of "the new way," as they term instruction in obstetrics. No nurse or medical student ever completed his learning in the lecture room; it is on the wards, in the clinics, and in actual practice that learning is com-

pleted. So it is with midwifery instruction, and the continuation of this instruction in the home takes us into midwifery supervision.

SUPERVISION

The midwife supervisor will ask herself: How is this midwife who was so interested in the classes taking care of her patients in the home? How does she prepare her patient for delivery? Does she really use the paper pads and clean cloths that she thought were so suitable in class? Is she helping her patient to have as easy a labor as possible? Is she protecting her from infection? What does she do to prevent postpartum complications? These questions can only be answered and the results of the teaching determined by observation of her conduct of labor and delivery in the home. A postpartum visit to the patient is not enough.

When the midwife understands that the nurse is really interested in helping her and her patient, she is quite willing to have the supervisor come into the home at the time of delivery. It has been found that the midwives who used the services of the nurse most showed the most marked improvement in technique.

Of the two aspects of supervision, the teaching and the law-enforcing, the former should always be most in evidence. If teaching and demonstration have failed, then steps can usually be taken to enforce the existing laws. The midwife who breaks the laws is usually known to the supervisor. If after teaching the midwife and emphasizing the principles of good care, she still disregards the laws, she is usually asked to retire—as this is preferable to a court action. Wherever state laws for the control of midwives are lax or nonexistent, nurses can exercise no small part in fostering adequate measures of legal control in their respective states. One of the most effective legal measures

which nurses can sponsor is annual licensure for midwives.

The inspection of equipment is another activity of the supervisor. After the midwife has been outfitted she should be given opportunity to replenish her bag at intervals at the lowest possible cost to her. In addition to a semiannual inspection, the supervisor notices the presence or absence of complete equipment each time she is called upon to work with the midwife.

A well kept record of each midwife's activities is helpful in determining her fitness for work, as it gives an account of her preparation and special problems.

In the supervision of the county groups of midwives, the supervisors have tried to teach the patient as well as the midwife that there is more to midwifery than "catching" the baby and

tying the cord. Throughout the instruction period, the midwife as a teacher in her district is emphasized.

The midwife becomes an active public health agent when she assumes the responsibility for getting her patients in to doctors or antepartum clinics for care, when she takes an active part in the syphilis-control campaign by reporting cases and by taking blood specimens from the cord for Wassermann testing, when she uses the available medical and nursing services in time of doubt or need, when she takes pride in doing good work, and finally when she teaches the mother the best care of herself and of her baby. It is this type of midwifery that adequate teaching and supervision will foster.

Presented at the N.O.P.H.N. Round Table on Midwifery Supervision, Biennial Convention, Kansas City, Missouri, April 27, 1938.

Hints for Parent Education

BY URSULA COX

Medical Officer, Carnegie Infant Welfare Institute, Birmingham, England

A teacher of parents should remind himself frequently that he is not infallible

THE DESIRE to teach, in the sense of an itch to impart information, is a widespread human attribute. Even more intense than the desire to be informative is the urge that every individual has to express his views. These views may be rational or may be founded on prejudice; and the more deeply opinions are rooted in prejudice and the less they are supported by evidence, the greater is the keenness with which they are expounded.

One of the gravest dangers to which

the teacher of so wide a subject as the care of children is exposed is the opportunity which is open to him to express his own views as if they were absolute truths, and his liability to come to regard as knowledge what is, in fact, merely his individual opinion. We who endeavor to teach the art of child-rearing are exposed to a danger from which the teacher of mathematics or chemistry is relatively immune; for he has to impart information which is precise and capable of verification, and he is, moreover, teaching his pupils not to accept unproven statements but to follow a line of reasoning, so that the teacher's own teaching should have taught his students to detect inaccuracies. But we teachers of parents are frequently mak-

Paper presented at 7th English Speaking Conference on Maternity and Child Welfare, London, June 2, 1937. Reprinted from *Mother and Child*, London, July 1937.

ing statements which we believe to be true, but which are only imperfectly, if at all, susceptible of proof. And we are addressing ourselves to people who are obliged to take much of what we say on faith, because it is quite impossible to impart to them a training such as that which we have ourselves received, which might enable them to detect a fallacy. For this reason I hold that one of the first essentials in a teacher of parents is that he should be able to remind himself at frequent intervals that he is fallible.

This sense of responsibility, and the capacity to be perennially learning and revising one's opinions, combined with imagination, understanding, and sympathy are, I think, the most important qualifications for those who aspire to educate parents in the care of their children. A teacher possessing these assets can give much help to parents even while giving only a small amount of definite instruction, while the teacher of domineering personality dogmatically insisting on all the textbook "do's" and "don't's" often does a great deal of positive harm.

The essential thing about individual advice to a mother is to tell her what she wants to hear. I do not mean by this that it is necessary to express agreement with all her methods of handling her baby, but that disagreement must be expressed in a form which she can accept. To give advice which a mother is mentally incapable of accepting, sometimes probably because of her attitude towards her own parents in her childhood, is only to increase her anxiety and to do harm. A frequent example of this sort of thing occurs when enthusiasts for breast feeding, of whom I am one, try to make a mother feed her baby when she has an antipathy, usually unconscious, to doing so. This unwillingness to breast-feed results in a scarcity of milk, and the mother eagerly decides that the breast is not satisfying the infant and puts him on the bottle. To tell such a mother that it is her duty

to feed the baby at the breast and that she ought to try, is to increase her sense of guilt and harmfully affect her relations with the infant. It is advice which she is mentally incapable of accepting, and she usually listens to it with a look of stubborn hostility. On the other hand, she gladly receives minute instructions as to the preparation of the bottle and her sense of guilt lessens as she follows them out and the baby gains weight and flourishes. It can never be anything but harmful to talk to a mother in such a way as to increase her anxiety or give her a feeling of inferiority, and the essential of individual advising is that the mother's self-confidence should be increased, not diminished. For this reason I think that negative injunctions are seldom helpful unless followed up by positive ones.

From good mothers, that is to say, mothers who are successful in keeping children healthy and happy, doctors and nurses can continually be learning. When one has been in the habit of giving a particular piece of advice on what appeared to be sound physiological grounds, and one discovers that good mothers constantly find it goes against the grain, one should very seriously doubt the validity of one's theory.

There is one other form of teaching which I think should not be overlooked—because its effect, though indirect, may be very considerable—and this is teaching by example. A mother visiting a welfare center and finding that the children are always spoken to by the staff in a gentle manner, that undue noisiness is checked with good humor, and that physical force is never used as a means of coercion, is not uninfluenced by these things. A health visitor has innumerable opportunities, both in the center and in the home, of giving an object lesson in how to turn a cross or perhaps frightened child into a smiling one.

It is a great pity to have any avoidable crying in the center. Children who

attend regularly raise no objection to the routine of undressing and weighing. They enjoy it. But a small newcomer may be genuinely frightened. I am strongly of the opinion that if gentle coaxing will not persuade him to be undressed and weighed this should never be done forcibly. To use or allow the mother to use physical force angers and frightens the child and is bad for the mother. The rule should, I think, be that in these circumstances the child is allowed to watch the other children in the weighing room and then come into the consulting room without undressing. No attempt at a physical examination is made, but the doctor is able to get on to friendly terms with mother and child and the former is asked to attend as often as she can in order that the toddler's timidity may be overcome.

The mother often calls the child who cries, "naughty," and is ashamed of him. By showing her that we do not regard his fears as naughtiness we increase her self-confidence and improve her attitude to him—the more so if we can succeed in overcoming his distrust, making friends with him, and telling his mother, in all sincerity, that he is a dear little creature.

Throughout these pages, I have chiefly used the word "mother," and some of my remarks obviously do not apply to fathers; but the educational principles by which I think the teacher should be guided are the same, whichever parent he is addressing. We very seldom have the opportunity of giving individual advice to fathers, and a good deal of propaganda is certainly still needed to induce them to realize the importance of the part they play in the lives of their children, however young.

In conclusion, I beg permission to point out the obvious fact that most adults are parents and that the average person in his capacity of parent is very much what he is in any other capacity and what his teachers are—a mixture compounded of a little reason and much prejudice. As teachers we have to encourage the reasonableness and deal tenderly with the prejudice, as we would have others deal gently with our own prejudices. But prejudices in teachers are dangerous, and we can only curb the dangers inherent in our own prejudices by a good deal of self-analysis, so that we learn to recognize them and can thereby do our utmost to prevent their obscuring our objective view.

S.O.P.H.N.'s at the Biennial

EVERY State Organization for Public Health Nursing, with the exception of the Wyoming Branch, was represented by one or two members at the S.O.P.H.N. presidents' dinner on April 26, during the Biennial Convention in Kansas City, Missouri.

Hettie Seifert, President of the New Jersey Organization, presided. Grace Ross, newly elected President of the National Organization for Public Health Nursing, attended as the representative of the Michigan Branch. Dorothy Deming, General Director of the National

Organization, and other members of the national staff were also present.

Among guests at the dinner was Mrs. Arch Trawick, Director of Health Education, Davidson County Department of Health, Nashville, Tennessee, who expressed her belief that the development of sound programs in public health nursing can be greatly promoted by state organizations for public health nursing because they provide machinery for the coördinated effort of public health nurses and interested lay people.

Mrs. Frederick S. Dellenbaugh, Jr.,

President of the Massachusetts Organization for Public Health Nursing, described with enthusiasm a series of institutes for board members of public health nursing associations planned by the state organization and conducted in the spring of 1938 by Evelyn K. Davis of the N.O.P.H.N. staff.

Great interest was shown in the brief reports of state organization activities given by the state representatives. A few of the most frequent undertakings and some of those which were most unusual are as follows:

Several state organizations are working out plans for affiliation with the public health associations of their states. Frequently a state organization meets jointly with the public health association, and indeed functions very much in the capacity of a nursing section. Under this plan, a nursing section within the public health association becomes unnecessary, and nurse members are free to join other sections in which they are interested, such as child hygiene or health education.

Needless to say, reports from all the organizations mentioned plans for regular meetings with the state nurses' associations and the state leagues of nursing education in their respective states. Besides the usual N.O.P.H.N. membership efforts, a number of states reported that they have given life memberships to those whom they particularly wished to honor. Most states have planned some

kind of regional conferences or institutes—often in conjunction with the state departments of health, with other nursing groups, or with organized lay groups.

Most of them, too, are in some way helping to promote standards of fundamental nursing education. Some have participated in an effort to place a public health nurse on the state board of nurse examiners; others have assisted in finding practice fields in public health nursing for students; while still others have helped in recruiting a good type of student for nursing schools.

Many organizations have taken action in one way or another to promote the adoption of satisfactory standards for qualifications of public health nurses in their states. Two state organizations reported efforts to place needed and well qualified personnel in their state health departments. Several had worked for nursing legislation, and one had succeeded in securing passage of a permissive law for the employment of school nurses. Each report indicated useful and important work done and each brought forth questions and discussion.

Though the plan for a dinner meeting seemed to meet with approval, everyone agreed that the time for discussion was too brief, and plans for a whole day of conferences on S.O.P.H.N. are already under way for the next Biennial Convention.

R.H.



NOTES from the NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

HONOR ROLL

1 nurse

9 nurses

3 nurses and

8 nurses all

Have an equal chance
Of being on the
N.O.P.H.N. Honor Roll
Of 1938
Reenlist as a member now

Remember to let us know when you're
On "top" with 100% enrollment and
Let us reward you for your
Loyal support

Asterisks denote the number of years
an agency has been on the Honor Roll,
up to five years. The dagger indicates
those agencies which have been Honor
Roll members for five years or more.

ALABAMA

**Fayette County Health Department,
Fayette
*Butler County Health Department,
Greenville
**Dallas County Health Department,
Selma

ARKANSAS

*Woodruff County Health Unit, Augusta

CALIFORNIA

*San Jose Chapter, American Red Cross
Visiting Nursing Service, San Jose

COLORADO

*Cheyenne County Public Health Nurse,
Cheyenne Wells
†Colorado Tuberculosis Association, Den-
ver
**Arapahoe County Schools, Englewood
**Colorado State College of Education,
Greeley
***Greeley Public School, Greeley
**Grand County Nursing Service, Hot Sul-
phur Springs
****Johnstown Public School, Johnstown
**Lamar Public School, Lamar
**Prowers County Nursing Service, Lamar
**Washington County Nursing Service,
Pueblo
**Costilla County Nursing Service, San
Luis
**Trinidad Public School, Trinidad

CONNECTICUT

***East Hampton Public Health Nursing
Association, East Hampton
****Haddam Public Health Association,
Haddam
**Madison Public Health Nursing Associa-
tion, Madison
**Visiting Nurse Association of New Brit-
ain, New Britain

GEORGIA

**Union Bag & Paper Corporation, Savan-
nah

INDIANA

***Elkhart Child Welfare Association, Elk-
hart
†Evansville Public Health Nursing Asso-
ciation, Evansville
***John Hancock Mutual Life Insurance
Nursing Service, Gary
**Lake County Tuberculosis Association,
Gary
†Huntington Public Schools, Huntington
†Bureau of Public Health Nursing, State
Board of Health, Indianapolis
****Floyd County Tuberculosis Association,
New Albany
***New Castle Public Health Nursing As-
sociation, New Castle
***Valparaiso School Nursing Service, Val-
paraiso
***Metropolitan Life Insurance Nursing
Service, Vincennes
†Delaware County Tuberculosis Associa-
tion, Muncie

IOWA

****Public Health Nursing Association of
Cedar Rapids, Cedar Rapids
****State Department of Health, Public
Health Nursing Division, Des Moines
*Health District No. 1, State Department
of Health, LeMars
****Monona County Chapter, American Red
Cross, Onawa
**Public Schools, Sioux City

KANSAS

***Arkansas City Public Health Nurse As-
sociation, Arkansas City

KENTUCKY

*Madison County Health Department,
Louisville
*Johnson County Health Department,
Paintsville

MAINE

***Augusta Red Cross Nursing Service,
Augusta

MASSACHUSETTS

***District Nursing Department, Lawrence
General Hospital, Lawrence

MICHIGAN

[†]Public Health Nursing Service of the Civic League and City of Bay City, Bay City
 **State Department of Health, Division of Public Health Nursing, Lansing

MISSISSIPPI

****Lauderdale County Health Department, Meridian

NEW HAMPSHIRE

****Portsmouth District Nursing Association, Portsmouth

NEW JERSEY

[†]Red Bank Public Health Nursing Association, Red Bank

NEW YORK

*Westchester Center, Henry Street Visiting Nurse Society, Bronx
 **Orange County Committee on Public Health, Goshen
[†]Village-Town Public Health Nursing Service, Kenmore
 *Wayne County Public Health Service, Newark

NORTH CAROLINA

*Pitt County Health Department, Greenville
 *Tri-County Health District, Murphy
 *Jackson County District Health Department, Sylva

NORTH DAKOTA

^{**}Ramsey County Nursing Service

OHIO

[†]Metropolitan Life Insurance Nursing Service, Cincinnati
[†]Western Reserve University Public Health Nursing District, Cleveland

OKLAHOMA

*Beckham County State Department of Health, Sayre

OREGON

*Lake County State Department of Health, Lakeview
 **Jackson County Health Department, Medford
[†]Clackamas County Health Unit, Oregon City
 **Multnomah County Public Health Association, Portland
[†]Visiting Nurse Association, Portland

RHODE ISLAND

^{*}East Providence District Nursing Asso-

ciation, East Providence
[†]Providence District Nursing Association, Providence

SOUTH CAROLINA

^{*}County Health Department, Florence

SOUTH DAKOTA

*Meade County State Board of Health, Sturgis

TENNESSEE

****Metropolitan Life Insurance Nursing Service, Chattanooga
 ****Lincoln County Health Department, Fayetteville
 *Bledsoe-Sequatchie Public Health Unit, Pikeville
 *Gibson County Department of Public Health, Trenton

TEXAS

^{*}Gulf Oil Corporation, Houston

VIRGINIA

^{*}Instructive Visiting Nurse Association of Arlington, Arlington

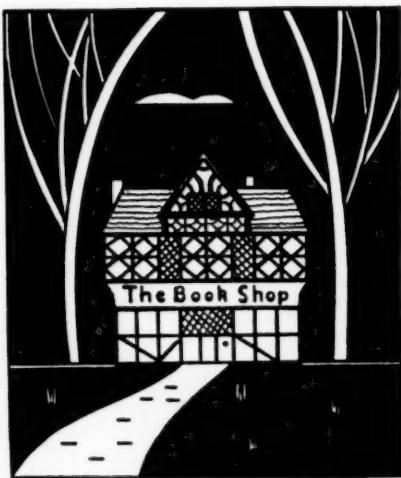
DELIVERY SERVICE

Are you considering starting a delivery nursing service? The folder of material on delivery service assembled by the N.O.P.H.N. will tell how many other agencies are meeting the same problems that confront you. It tells how the delivery service is administered by each of 30 public health nursing agencies—the size of staff, extent of service, methods of publicity, hours of service and arrangement of calls, time spent on a delivery, fee schedule, supplies, and other facts of interest. A bibliography is appended. Obtainable from the National Organization for Public Health Nursing, 50 West 50 Street, New York, N. Y. \$2. On loan to N.O.P.H.N. members for transportation costs only (both directions). On loan to non-members, 50 cents plus transportation costs.

NOTICE TO J. V. S. REGISTRANTS

The National Organization for Public Health Nursing will make arrangements for the transferral of nurses' vocational records from the Joint Vocational Service to Nurse Placement Service UPON REQUEST of the individual nurse. If no request is received, the vocational records will be stored by the N.O.P.H.N. and may be transferred at any time later upon request. (See June issue, page 371.)

Vacation Reading



By Kate Coe, Englewood, New Jersey

We are again publishing reviews of suggested summer reading, in this issue, as our contribution to a pleasant vacation.

THE YEARLING

By Marjorie Kinnan Rawlings, 428pp. Charles Scribner's Sons, New York, 1938. \$2.75.

This is a most delightful story of a boy, who without opportunities for education, contemporary companions, proper environment, food, or care according to accepted present-day standards has a not unhappy boyhood and gives promise of an honorable manhood. The reason: a father who had had most of these advantages; and who, though living in poverty and constantly fighting the forces of nature and predatory beasts in order to win existence from a small farm, has a hard-won philosophy of life, a sense of humor, and an understanding of a young boy's nature that are unusual to say the least. The aliveness of the characters and the reality of their environment could not be adequately portrayed in any review of this entirely charming book.

MARY E. G. BLISS, R.N.
New York, N. Y.

R.F.D.

By Charles Allen Smart, 314pp. W. W. Norton and Company, Inc., New York, 1938. \$2.50.

People who have always in their secret hearts wanted to become gentlemen and lady farmers will thoroughly enjoy *R.F.D.* It is written by a young man who fell heir to an old farm near Chillicothe, Ohio. He had spent many of his childhood vacations on the place and loved it, but had never done farming for a livelihood. He had taught, written, and traveled. And his wife, whom he married soon after the acquisition of the farm, came with the background of a New England Eastern college graduate and professional experience as a girl scout executive.

The book combines a delightful description of the vicissitudes and pleasures of farm life, a frank description of the difficulties of making a living on the land, and detailed descriptions of fertilizers, and animal husbandry—mixed with delicious humor and sympathetic character-analysis of the natives of the community.

E.K.D.

THE CITADEL

By A. J. Cronin, 401pp. Little, Brown and Co., Boston, 1937. \$2.50.

"Success stories" are being written every day, but there are few that are told with the interesting reality with which A. J. Cronin presents *The Citadel*.

It is the story of a young physician who finds himself plunged into his profession as an "assistant" to an ailing, semiparalyzed doctor in a rural mining district in England.

Step by step he progresses from this position of responsibility to one of even greater responsibility and respect, and step by step he becomes more and more prosperous. Accompanying this change in position is a change in himself. He

discards the ideals of his younger days and succumbs to the easy standards of his wealthy, rather unscrupulous friends. This comes about slowly and it is not until a catastrophe occurs that he awakens to the reality of the situation.

Throughout the book runs a tender love story of the doctor and his school teacher wife. It is a story of their struggle for success and—success once attained—their struggle for happiness.

D.R.

DAWN IN LYONESSE

By Mary Ellen Chase. 115pp. The Macmillan Company, New York, 1938. \$1.75.

This poignant tale of a fisherman's daughter is permeated with the salty air of the sea, and something of its eternal mystery and timelessness. It is a story of toil and poverty and romance and death in the lives of simple folk, one of whom—the central character, Ellen Pascoe—suddenly finds a new world of beauty and imaginative fancies upon reading the great love story of Tristram. From the beginning, the setting in which the story is laid almost overshadows the characters—perhaps because human beings seem insignificant beside the overwhelming power of the sea. The story gathers dramatic force as it sweeps to its tragic close—a tragedy softened, however, by the revelation of a new depth of human understanding.

It is a short tale, easily read at one sitting, but not as quickly forgotten.

P.P.

WARRANT FOR X

By Philip MacDonald. 319pp. The Crime Club, Inc., selection. Doubleday Doran and Company, New York, 1938. \$2.

Public health nurses believe in prevention and so they ought to enjoy *Warrant for X*, which is a mystery story without a crime in its first 150 pages. During this space citizens, visitors, and detectives try to prevent an unknown

but impending crime. The outcome is rather more satisfactory than usual and the whole story is well told, with likeable, natural people suspecting, sleuthing, suffering, and succeeding. Pleasant vacation reading if you like the English way of writing detective stories. I do.

D.D.

THREE HINTS FOR SUMMER READING

Oleander River. By G. B. Stern. 375pp. The Macmillan Company, New York, 1937. \$2.50.

Peril at End House. By Agatha Christie. 177pp. Modern Age, New York, 1938. 25c.

The Flying Yorkshireman. By Eric Knight, Helen Hull, Albert Maltz, Rachel Maddux and I. J. Kapstein. 273pp. Harper and Brothers, Inc., New York, 1938. \$2.50.

Not too much science or philosophy is indicated for hot-weather reading. You will want something that won't strain your mind or run up your temperature.

Try G. B. Stern's *Oleander River*, the story of a boy who loved a girl who loved a man who loved another woman, and set enchantingly on the shores of the Mediterranean. It will stimulate your imagination with the things it leaves unsaid, and afford you numerous quiet chuckles along the way.

For that rainy afternoon get Agatha Christie's *Peril at End House*, a well knit and absorbing mystery story. If you have not met Hercule Poirot, the little French detective, make his acquaintance now. He is spending a week at an English watering-place when odd things begin to happen, and even his definite retirement from public life cannot prevent him from taking a hand in their solution.

And one more—*The Flying Yorkshireman*—a collection of five long short stories, or *novellas* as the publisher calls them. The title story is of a retiring little man who suddenly finds that he can fly just as a bird does, and dreadfully embarrasses himself, his family, and eventually the whole world, by this odd gift. The other stories are varied and interesting and unfailingly well

done. A book that you will delightedly lend to your friends when you have finished with it.

MARY BOOMER
New York, N. Y.

RED STAR OVER CHINA

By Edgar Snow. 474pp. Random House, New York, 1938. \$3.

All of us today feel some interest in what is happening in China. Because the names of places and leaders are so confusing to non-Orientals it is very difficult to follow the news. The geography and the political and social life of China are also somewhat of an enigma to us.

Edgar Snow has spent many years in China as a news correspondent. In June 1936 he seized an opportunity to penetrate into Northwest China, then held by the Communists. This book follows his travels over the territory for which a united China is fighting so desperately today. His interpretation of the political and social philosophies of both the Communists and the Kuo-Min-Tang, or "National People's Party," makes reading the daily news intelligible. The present united front brings a positive thrill when one realizes the schisms which formerly separated the various factions in China.

ELEANOR W. MUMFORD, R.N.
New York, N. Y.

QUANTITY RECIPE FILE

By Lenore M. Sullivan. 300 recipes. The Collegiate Press, Ames, Iowa, 1937. \$3.

Cooks who must provide for half a hundred people, whether it be coffee on a picnic or three meals a day in satisfying variety, will find useful information in this file of quantity recipes developed in the Institutional Management Department of Iowa State College. The instructions are precise and easy to follow, and the recipes are conveniently assembled for ready access in a standard 5 x 8 file.

M.R.

PLAY DIRECTION

By Allen Crafton. 264pp. Prentice Hall Inc., New York, 1938. \$3.50.

Since drama is passing from Broadway as a center and is being reestablished in thousands of communities throughout America — produced by schools, churches, social service groups and almost wherever two or more are gathered together—a book on play direction has a much wider appeal than it would have had a decade ago.

Play Direction, by Allen Crafton of the University of Kansas, covers each of the director's activities from the time he first reads the script to the night of the performance. The book, unlike many books on play production, is quite free of padding and material that has been used over and over. Whether one agrees with all the conclusions, the book is stimulating and helpful. And while it is written primarily for college students who plan to become directors of amateurs, it has a certain general interest in that it states clearly and excitingly the process through which a director, with only "green" amateurs to work with, may put on a good show.

L.H.R.

ELIZABETH FRY—QUAKER HEROINE

By Janet Whitney. 333pp. Little, Brown and Company, Boston, 1936. \$3.50.

This is a delightful pen portrait of a great and gallant lady. It opens with a characteristic picture of her during her carefree girlhood wherein she and her six saucy sisters string themselves, like a bright ribbon, across the highway to stop the stage coach. We see her fidgeting through the long, tiresome Quaker meetings. We follow her through adolescence when her indulgent, widowed father takes her down to London for the social season. There the merry round of theaters, operas, and teas alternates with Quaker meetings. She begins to search for some soul-satisfying activity. Then comes her "call" to ser-

vice and its practical expression in teaching the children of the poor followed by her well known prison reforms.

The scenes are vividly drawn. One fairly tastes the full flavor of that lost, leisurely, tolerant country life of England where the Quaker sisters read Voltaire, Tom Paine, poetry, and romance with their suitors and friends—among whom were Catholics, Methodists, and Church-of-Englanders as well as Quakers. Mrs. Whitney has done a real service in bringing it back to life. Elizabeth's hearty eagerness for doing good, her flaming purpose, her great common sense, her broadmindedness combined with practical idealism and motherliness, and her courage—all are compellingly portrayed. It is a book one will want to own. It is beautifully illustrated and easy on the eyes. Nurses will find it interesting not only for its literary and artistic value but for its methods in dealing with mental patients and social problems.

DAISY DEAN URCH, R.N.

*College of St. Teresa,
Winona, Minnesota*

FOR DEAR LIFE

By Belinda Jelliffe. 355pp. Charles Scribner's Sons, New York, 1936. \$2.75.

For a vacation treat read this autobiography of a nurse—this "rags to riches" story of a self-made woman. Her amazing adventures read like a thrilling novel, but the book is not fiction. It is the true life-story of a courageous and determined woman.

On the little North Carolina farm where she was born in a barn she made early and grim resolution to escape to a happier environment. With only fifty cents and a scanty supply of clothing she ran away from home to find the place where there were books—where she could be "educated." She found the schools she craved, working her way as a servant girl. Finally, she entered a New York hospital school of nursing.

The hospital adventures are graphically and realistically told. As a sequel to the years in training came spiritual upheaval and struggle for adjustment. Out of this period of storm and chaos, fate was unexpectedly kind.

The author is the wife of Dr. Smith Ely Jelliffe, prominent New York psychiatrist.

MINNIE G. MCLEMORE, R.N.
Martinsville, Virginia.

THE THOUGHT-READING MACHINE

By André Maurois. Translated by James Whitall. 217pp. Harper and Brothers, New York, 1938. \$2.

Have you ever contemplated the fascinating and appalling possibilities of a "wire-tapping" apparatus which would tune in—not on the conversations but on the thoughts of others? An author with a gift of imagination as well as a penetrating but tolerant observation of human beings has built a novel around this theme. In a story which is a comfortable afternoon's reading, André Maurois plausibly portrays the invention of such a machine by a physics professor, the results of its experimentation with various members of the little college community as subjects, and the marketing of the apparatus—an amusing satire on modern advertising. Its ultimate effect upon the destinies of mankind the reader is left to find out for himself.

It is worth mentioning that the type is especially easy to read. P.P.

MADAME CURIE

By Eve Curie. Translated by Vincent Sheehan. 393pp. Doubleday, Doran and Company, New York, 1938. \$3.50.

This interesting study of Madame Curie and of her family presented by her daughter Eve, commences with her mother's early childhood in Poland. She grew up in a nationalistic group greatly resenting the oppression of Russia.

Her daughter depicts Madame Curie's struggles and triumphs. Her scientific education and success were attained

through her grim determination and self-denial. Yet one does not feel that she was a martyr, for to her science was its own reward, bringing greater joy than any physical comfort or social success could do.

Much of Madame Curie's work was founded on that of her husband and coworker, Pierre Curie. This she readily acknowledged throughout her life. They were apparently exceptionally well mated.

And what of the biographer—daughter of an illustrious mother? Why does she feel it necessary to so greatly stress sentimental aspects of her mother's life? Why repeatedly speak of her mother's beauty? Why the emphasis on the intellectual qualities of ancestors—both maternal and paternal?

ELEANOR W. MUMFORD, R.N.
New York, N. Y.

FASHION IS SPINACH

By Elizabeth Hawes, 337pp., Random House, Inc., New York, 1938, \$2.75.

Do you wilt when a satin clad, pearl-earringed saleswoman comes sailing down with a haughty air to greet you as you enter the dress department? By this time you have probably met her counterpart in five other stores during the day, and are still inquiring in a feeble voice for a navy blue silk dress. You know her answer will be, "Why, no, blue isn't fashionable this year." You will probably wind up with a brown dress, and regret it.

Before your next shopping expedition, fortify yourself by reading this book.

On her graduation from Vassar the author went to Paris and became convinced that the reverence for French clothes is based on a myth. The mystery which shrouds original French designs and the intrigues used to copy them make fascinating reading.

To Miss Hawes, women fall into two categories—those whose clothes are made to order and those who buy them ready-made. Fashion dictates what the

latter will wear, and produces them *en masse*; those who order their clothes made to their individual taste purchase style. Style is expensive, but it is a quality which is not outmoded.

The hopeful note in the book is that with a growing style-consciousness among the consumers of ready-made clothes, they can influence what is offered to them.

The author's breezy *New Yorker* manner will hold your interest and you will rejoice in the triumph of this young American designer against the dragon Fashion, whom she sets out to slay.

ANNA J. MILLER
Sunnyside, New York

JOSEPH IN EGYPT

By Thomas Mann. Translated from the German by H. T. Lowe, 2 vols., 700pp., Alfred A. Knopf, Inc., New York, 1938, \$5.

This is the third book in an unfinished series by Thomas Mann, in which *Joseph and His Brothers* was the first, and *Young Joseph* the second. In these books the author converts old biblical material into a story of considerable significance for the modern reader. One reviewer spoke of the sense of timelessness in the author's interpretation of these semihistorical figures of the past.

Joseph in Egypt carries on the story of Joseph as the successful young overseer in the sumptuous palace of Potiphar, the courtier, and of Joseph's association with Eni, the priestess of the temple and Potiphar's wife. The tracing of the growth of a personality in the social environment, and the sense of inner consecration which Joseph continues to experience, are central ideas. The book is an artistic expression of the author's philosophy, and it is fiction of the first order. It is particularly recommended to those who enjoy rather serious reading and who wish to keep in touch with the best in contemporary literature.

HELEN W. GOULD
Greenwich, Connecticut



• Public health nurses throughout the country will be interested in the appointment of Elizabeth J. Mackenzie as assistant in the development of public health nursing placement and counseling in the Nurse Placement Service, Chicago, Illinois. She began her work on July 1, when the transfer of the nursing division of Joint Vocational Service in New York City to the Nurse Placement Service became effective. (See PUBLIC HEALTH NURSING, June 1938, page 371.)

Miss Mackenzie will be missed greatly in New York City, where for many years she has held the position of Associate Director of Nurses (and for a time Acting Director) of the Henry Street Visiting Nurse Service. Previous to that she was assistant to the Director of the Nursing Bureau, Alabama State Department of Public Health. She has also taught under the extension division of the University of Alabama. She has done rural county nursing in Alabama and urban visiting nursing with the Philadelphia Visiting Nurse Service. As evidence of her interest in personnel work, she has served as a member of the Board of Directors of Joint Vocational Service.

She is a graduate of Presbyterian Hospital School of Nursing in New York City, has a B.A. degree from the University of Toronto, Canada, and has done postgraduate work at Teachers College, Columbia University, New York City.

Miss Mackenzie brings to her new work a rich background of both urban and rural public health nursing, and the point of view of the nurse, the employer, and the teacher.

• The National Tuberculosis Association announces the endorsement by Dr. Thomas Parran, Jr., Surgeon General of the U. S. Public Health Service of a suggested national program for eradication of tuberculosis in the United States at a cost of nearly \$200,000,000. The proposed program, to start in 1939, would include the construction of 40,000 hospital beds for tuberculosis patients and the x-ray of all persons who have had family contact with known cases of tuberculosis. The plan contemplates a combination of federal, state, and local efforts under federal leadership.

• The Maternity Center Association in coöperation with the Department of Nursing Education of Teachers College is offering a two months' course in advanced maternity nursing for a limited number of maternity supervisors in the field of public health nursing. (This course is not to be confused with the four months' and eight months' courses in advanced maternity nursing offered regularly at Teachers College in co-operation with the Maternity Center Association.) Included in the course will be lectures on obstetrics, community maternity nursing, and other subjects affecting the care of maternity patients; supervised field observation; round table discussion of administrative and other problems; assigned reading; and study hours.

Registrants are requested to write directly to the Maternity Center Association, 1 East 57 Street, New York, N. Y., giving name, address, and position held. Registration will be closed on September 2 or sooner if a sufficient number register. Students matriculated

in the Department of Nursing Education at Teachers College should indicate on admission if they wish to work for credit. Six points of credit will be given for the unit, and the regular college tuition fees will be charged. Students not applying for credit will be charged a flat registration fee of \$50. It is possible to keep living expenses within \$75 a month. Registrants will be sent a list of places where they may secure rooms at reasonable rates.

• The Board of Directors of the Northern Dutchess Community Nursing Service, Rhinebeck, N. Y., has announced the appointment of Mrs. Marion Wetzel as the director of that organization. This new community nursing service, as it is being organized, represents an attempt at coördination of all nursing service in the community. All requests for nursing service will be cleared through its office, which will be located in the Northern Dutchess Health Service Hospital in Rhinebeck. Consultation service from the Joint Committee on Community Nursing Service of the three national organizations is being used in developing this new service program. Mrs. Wetzel will assume her new position in August, coming from the Huntington, West Virginia, chapter of the American Red Cross.

• Smallpox is on the increase in the United States, according to the Statistical Bulletin of the Metropolitan Life Insurance Company for May 1938. In 1937, there were 11,806 cases as against 7844 in 1936. Strangely enough, most of the cases of this disease occur in some of the least populous states. The Northwestern states—Washington, Oregon, Idaho, Montana, Wyoming, North and South Dakota, and Nebraska reported 14,203 cases for the five-year period, 1933-1937; whereas the Eastern states of Massachusetts, Rhode Island, Connecticut, New York, New Jersey, Penn-

sylvania, Delaware, and Maryland, including the District of Columbia, reported only 256 cases for the same period. Attention is called to the fact that since smallpox thrives in all climates, the high prevalence in the Northwestern states cannot be attributed to weather conditions. It must, therefore, be due to the popular attitude toward the practice of vaccination.

• Two scholarships of \$1250 each in the Florence Nightingale International Foundation in London are to be given annually to nurses for the ensuing five years by the American Red Cross in memory of Clara Dutton Noyes. One scholarship is to be awarded each year to an American nurse and one to a nurse from a foreign country. The candidate from the United States will be selected by the American Red Cross, the American Nurses' Association, and the Florence Nightingale Foundation Committee, and the nurse from a foreign country will be recommended by the League of Red Cross Societies and the International Council of Nurses.

The nurses winning the scholarships will live in the Florence Nightingale Foundation house at 15 Manchester Square, London. They may elect three courses—covering public health, nursing administration, and teaching in schools of nursing—offered by Bedford College in conjunction with the College of Nursing.

• The Division of General Education of New York University in coöperation with the National Conservation Bureau will offer eighteen research fellowships in safety education, providing an annual stipend of from \$400 to \$1200, for graduate students enrolled in the School of Education of the University during the academic year 1938-1939. Fellowships will be open to men and women who are graduates of accredited colleges or universities and who are candidates for

a higher degree. Applications are especially desired from teachers, supervisors, and administrators in public schools and from instructors in teacher-education institutions. The purpose of the fellowships is to aid in discovering educational procedures which will be helpful in developing effective attitudes toward the problems of safety, and to prepare teachers who are interested in and qualified for participating in safety education.

- The Chamber of Commerce of the United States in coöperation with the American Public Health Association has announced the following first awards for the 1937 City Health Conservation Contest:

Group I—Cities of over 500,000 population—Boston, Mass.

Group II—Cities of 250,000 to 500,000 population—Louisville, Ky., and Providence, R. I.

Group III—Cities of 100,000 to 250,000 population—Hartford, Conn.

Group IV—Cities of 50,000 to 100,000 population—Sacramento, Calif.

Group V—Cities of 20,000 to 50,000 population—Greenwich, Conn.

Group VI—Cities of less than 20,000 population—Englewood, N. J.

The prizes were for the most effective efforts to meet local health problems. They were not based on health department programs alone but rather on the communitywide efforts of all agencies and groups, including the work of private physicians and dentists.

This year, as a part of the City Health Conservation Contest, awards were made for the most effective communitywide programs for syphilis control and tuberculosis control. The winner in the syphilis-control contest is Tacoma, Wash., and in the tuberculosis-control contest, Detroit, Mich. In selecting the winners such factors as the following were considered: the comprehensiveness of case-finding and follow-up services in connection with tuberculosis and syphilis, the facilities provided for diagnostic and treatment pur-

poses, and the extent of group participation in programs of education and control.

In the Rural Health Conservation Contest this year—conducted under the same auspices and financed by the W. K. Kellogg Foundation of Battle Creek, Mich., the rural health units of Canada were included in the contest for the first time. The winners for 1937 are:

Northeastern Division—Columbia County, N. Y.

Eastern Division—Fayette County, Ky.

Southeastern Division—Pike County, Miss.

North Central Division—Woodbury County, Ia.

South Central Division—Amarillo-Potter County, Tex.

Western Division—Clallam County, Wash.

Canada—St. John's, Iberville, Napierville Counties Health Unit, Quebec

- An assembly of laboratory directors and serologists, under the sponsorship of the Committee on Evaluation of Serodiagnostic Tests for Syphilis of the U. S. Public Health Service, is planned for October 21 and 22 at Hot Springs National Park, Ark. The purpose of the assembly will be to consider methods to improve and to make more generally available the serologic tests, which are so important in syphilis control work.

- Dr. Estella Ford Warner has been appointed editor of the Public Health Section of *The Medical Woman's Journal*. Dr. F. B. Sherbon, the retiring editor, will remain on the *Journal* editorial board.

- An exhibit presenting the powerful weapons which can be used in the war to conquer cancer will be arranged by the New York City Cancer Committee of the American Society for the Control of Cancer at the New York World's Fair in 1939. The exhibit will include lifelike models of M. Curie and his wife at their work bench watching a substance which glows, in symbolism of their tremendous discovery. The keynote of the exhibit is one of hope showing that cancer, if adequately treated in time, is curable in a large percentage of cases.

Our Readers Say . . .

THIS COLUMN is intended to serve as a forum for the expression of reader opinion. Only signed letters will be published, although the signature will not be used except with the writer's permission. The National Organization for Public Health Nursing is not responsible for opinions expressed on this page.

WHAT A PHYSICIAN THINKS OF US

To the Editor:

I appreciate the kind reception given my paper before the Biennial Convention at Kansas City.*

I would like to repeat in substance my extemporaneous remarks in introduction. It is something which I have often said to groups of doctors who were "crabbing" about public health nurses injuring doctors, but I have never before had an opportunity to say it to the nurses themselves:

As a doctor I want to thank you for what public health nurses are doing for the medical profession.

In recent years many doctors are greatly alarmed by the fear of state medicine. Some of them are almost hysterical on the subject. The falling off of income which has affected doctors, just as it has every other group in the country, has intensified this alarm. They are prone to blame it on the activities of government and philanthropic foundations in the field of public health. They forget that the control of infectious diseases and many types of preventive medicine have always been the duty of local, state, and national officials.

It is true that occasionally a school nurse or a district nurse has some child vaccinated or given toxin-antitoxin or examined in a free clinic, when the parents might have paid a small fee to a private doctor. This is not surprising. The parents are indifferent or stingy and the nurse wants to report 100 percent immunized, or is truly concerned about the health of the child.

When this happens some doctors raise a great hue and cry and complain bitterly that private practice is being wrecked by the public health nurses. What they forget is that for every dollar doctors may lose in this way they get fifty dollars worth of free advertising from these same nurses.

Doctors are not permitted to advertise themselves individually and are not willing to spend money on mass advertising. Public health nurses are always explaining the facts of scientific medicine and urging people to consult their doctors. They do not recommend the cults. They always boast of organized medicine.

As a representative of that fraternity it gives me great pleasure to acknowledge this loyalty and this valuable service and to thank you one and all.

ROBERT MCE. SCHAUFFLER, M.D.
Kansas City, Mo.

MATERIAL ON SUPERVISION NEEDED

I am taking a course in public health nursing at the present time, and one of my subjects is "Supervision in Public Health Nursing." After searching for materials, the entire class has agreed that more material is most needed in this field.

I read the article by Miss Peterson on "The Rural Nurse's Day," with great interest and I feel that it is very practical and that more articles of this type would be of much help to us who are working in the field, particularly where our program is new.

Laura Van De Mark, R.N.
Oklahoma State Department of Public Health.

MISSISSIPPI NURSE USES MAGAZINE

I have been an interested reader of your magazine for nearly ten years. It has been of inestimable value to me in my profession as public health nurse, and I feel that every public health nurse in Mississippi should be a habitual reader of so valuable an aid to her in her work. I fully realize with regret that there are too few nurses in my state who belong to the N.O.P.H.N.

ELLA M. SAYLE, R.N.
*Pike County Health Department,
McComb, Mississippi*

*"Prevention of Orthopedic Disabilities,"
published in June 1938 issue, page 379.



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